Adult Psychiatric Services Provided by General Hospitals

Guidelines

Canada

89-02706/

Report of the Subcommittee
on Institutional Program Guidelines

Guidelines for Establishing
Standards for Special Services
in Hospitals

ADULT PSYCHIATRIC SERVICES

PROVIDED BY

GENERAL HOSPITALS

Health Services Directorate
Health Services and Promotion Branch

Published by authority of the
Minister of National Health and Welfare
1988

Également disponible en français
sous le titre
"Soins psychiatriques aux adultes dispensés
par les hôpitaux généraux"

NOTE

The information contained in these guidelines is considered current as of the date of approval; however, since many aspects of health care and health technology are constantly changing, we welcome any suggested amendments. Information on new developments or related issues should be directed to:

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Cat. No. H39-10/1988E
ISBN 0-662-16549-7

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PREFACE

Technological advancement and changes in the delivery of health care services have led to the need for guidelines to assist in planning and implementing institutional programs and services. The guidelines that follow are one of a series produced under the direction of the Subcommittee on Institutional Program Guidelines. They describe requirements for a number of special care units, services and programs in health institutions.

In general, guidelines are based on information, knowledge, experience, research and expert opinion from health professionals and others throughout Canada. Additional material is often obtained from national and international health organizations. In this way many Canadians from across the country have contributed to the guidelines and consensus has been achieved.

Background

The guidelines program has been in operation since 1972, under the direction of the Federal/Provincial Advisory Committee on Institutional and Medical Services. The Subcommittee on Institutional Program Guidelines is a standing Subcommittee of the Advisory Committee. It is composed of federal and provincial government and professional representatives and coordinates the development of the guidelines commissioned by the Advisory Committee.

The guidelines are produced by expert working groups; they are reviewed by the Subcommittee and recommended to the Advisory Committee for approval.

Purpose

The purpose of the guidelines is to provide a comprehensive description of requirements for services in health institutions. While a consensus of expert knowledge and experience is reflected in them, they should not be regarded as rigid standards; they may be modified to meet the needs of specific situations.

Where development of a service is being contemplated, the guidelines should help to determine the need for the service either locally, regionally, or in some cases provincially or interprovincially.

Established services may take advantage of the guidelines to screen for deficiencies and solve problems. The guidelines will help:

- to identify problems related to administration, personnel, equipment and facilities;

- to determine necessary remedial action;

- to set priorities for corrective measures on the basis of clinical need, funding and the degree to which the service is deficient.

Future

The dramatic increase in the number of intensive and special care services in health institutions has given rise to the need for additional facilities, specialized equipment and highly trained personnel. At the same time, new approaches to patient care have evolved in a manner that emphasizes the need for a continuum of care in which admission to an institution is only one aspect of total care. Therefore, linkages along the health care continuum, ranging from illness prevention to chronic care, must be identified. As new treatments and procedures are developed, there is a continuing need for guidelines to assist those involved in the planning and operation of related institutional services.

Revisions

Due to the rapidly changing nature of health care delivery, guidelines will need updating and revision. The Subcommittee on Institutional Program Guidelines plans and oversees these revisions.

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ACKNOWLEDGEMENTS

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A. INTRODUCTION

INTRODUCTION

The objective of a mental health service system is to help people to reach their optimal level of mental health and to maintain them in the community. Mental health service structures therefore need to be comprehensive, inter-related and well coordinated.

The general hospital is a major component in the network of care for persons who have psychiatric disorders or illnesses. General hospitals are increasingly providing a broad range of assessment, treatment and referral services to these persons and often act as catalysts in the development of community resources.

1. SERVICE NETWORK

This document is focussed on psychiatric services delivered by the general hospital, both in and out of the hospital building, in the context of a regional system[1] that includes services of other agencies, all operating within a catchment area. For patients to receive only what they need, when they need it and where they need it, systems of services delivery must be flexible; otherwise, there is a risk of patients being assigned to predefined programs rather than to programs designed to respond to their diverse needs. In rural settings general hospitals will not command the range of resources available in major cities but the hospital will be a key element in a network of referral, consultative and treatment services covering a wide area. Inadequate community support systems, both formal and informal, have the effect of increasing the length of stay for inpatients. This results in saturation of inpatient services with patients who could be treated in other settings and blocks beds that are needed for acutely ill patients who require inpatient care as part of their treatment.

2. A SPECIAL ISSUE

Within the general hospital, an important function of the psychiatric department staff is to educate other hospital staff and administrators with regard to alternative forms of psychiatric services and the benefits of developing community links and programs to reduce the demands on inpatient services. Too often, supportive and preventative roles, particularly those reaching into the community, are under-valued relative to the demand for more traditional medical and surgical

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1 See B.3 "Regional and Local Planning Considerations"

services. Psychiatric services prior to admission may be neglected while emergency admissions are perceived as necessary. Should this process continue, mental health funding may be shifted to meet immediate needs in emergency without considering the long-term effects of underfunding the community-based service. This will inevitably lead to increased pressure on emergency services. What must be critically evaluated are the trade-offs between allocating resources to community-based programs, which are not visible within the hospital structure but which have long-term gains, and continuing to support emergency services, which are essential and easily identified, thus creating an imbalance in the system. Such funding adjustments would be made within the budget for psychiatric services.

3. ROLE OF THE GENERAL HOSPITAL

Efforts to engage patients in community-based treatments have changed the nature of psychiatric admissions to general hospitals. Many who would probably have been admitted to hospital in the past are now treated in the community or in day hospital programs. While the goal is to maintain the patient in the community, hospital admission may be required because of the acuteness or severity of the patient's illness, scarcity of community resources, or lack of support systems necessary to maintain the person in the community. Even where the community resources are well developed, certain individuals will require hospitalization for recurrent acute episodes of illness. Many general hospitals are now providing services to former inpatients of large provincial psychiatric hospitals that no longer provide long-term care on the large scale that they once did.

Most general hospitals today have a range of psychiatric programs that play an extensive role in the provision of mental health care. Outpatient, partial hospitalization, consultation and liaison and emergency services have been developed to complement inpatient services; the resulting complex improves coordination and offers a wider range of service options. The functions include crisis intervention, assessment, access to specialized services and referral and linkage to community support services.

When a given hospital cannot provide specialized psychiatric services, the staff should, nevertheless, be thoroughly familiar with specialized and other services to which patients and members of the patient's family who are at risk, can be referred following assessment.

Hospital specialization, such as in forensic or geriatric psychiatry, has many advantages but also has some potential risks. The primary one is that departments of psychiatry may over-specialize to the degree that

general psychiatric services suffer; patients needing psychiatric care may be referred to other hospitals because their needs are not seen as "appropriate" to the specialized mandates of these departments. When several hospitals in an area are specializing to the extent that general services are inadequate, patients may not be able to obtain the treatment that they need in their home communities.

4. PREVENTION AND PROMOTION

In addition to providing direct care to psychiatric patients, the psychiatric staff have other significant roles, namely in community prevention and health promotion activities.

Prevention takes many forms and Caplan's classical definitions of primary, secondary and tertiary prevention are shown in Appendix I. The psychiatric service, through its ongoing liaison with community groups and other professionals, should assist in identifying local mental health risk factors and in formulating prevention strategies and programs, in collaboration with local agencies.

Because the general hospital is the place where members of the community most often come with their health-related concerns, it offers a unique opportunity for education about healthy lifestyles and early identification of risks; it also offers a unique opportunity for research on local variations and trends in mental health problems.

The responsibilities of the general hospital in health promotion include such challenges as reducing inequities in access to health care, expanding the scope of prevention and optimizing the circumstances and supports in the community that enable people to make the best use of their own resources. Hospital staff should therefore not be concerned only with the narrow and specific clinical diagnosis, but should also be aware of the general context within which the patient lives and interacts. They should be concerned with the effect that the patient's illness has on his or her family and social network, and vice versa, and should recognize the stress experienced by these others. They should take steps to minimize the impact of the patient's illness, particularly when it is children who are at risk.

Collaboration with other hospital departments and community agencies offers a wide variety of prevention and promotion opportunities. Examples of prevention activities aimed at high-risk groups are collaboration with intensive care and coronary care departments to incorporate stress reduction techniques and with emergency services to prevent secondary trauma in victims of violence or rape. Examples of promotion activities are collaboration with community groups, such as

schools and recreational associations, to develop mental health programs focussed on changing attitudes toward mental illness or enhancing skills for coping with normal life transitions.

In light of the diverse elements making up the role of the general hospital, the establishment of positions in different disciplines should be directly related to the several requirements of direct service but, at the same time, make allowance for the broader aspects of that role.

B. GENERAL CONSIDERATIONS

1. PRINCIPLES OF CARE

The following principles of care reflect the philosophy and approach of this document and are not listed in order of importance.

1.1 The general hospital psychiatric service should be an integral part of the mental health care system, acting as an agent to promote a comprehensive and coordinated system of institutional and community-based services in the area served.

1.2 General hospitals should be prepared to provide the initial management for patients with psychiatric disorders. Hospitals should strive to maintain staff with adequate training and experience.

1.3 Program goals should be comprehensive and include the provision of a full diagnosis and assessment service; the provision of high quality treatment and rehabilitation services; the early identification of persons at high psychological risk; and the prevention of mental illness and the promotion of good mental health.

1.4 Psychiatric programs provided by the general hospital should be coordinated with the other speciality services to avoid unnecessary duplication.

1.5 Basic psychiatric assessment and referral services should be provided to the community served by the general hospital.

1.6 The general hospital should be able to provide a full range of high-quality psychiatric treatment services through inpatient, outpatient and partial hospitalization modes. This requires a team of skilled practitioners who can bring expertise from several disciplinary backgrounds.

1.7 Care should be provided consistent with the needs of the individual patient. The competent patient accessing the service must have treatment given on the basis of informed consents.

1.8 Whenever possible, the family of a patient should be involved in the total assessment and care of that patient.

1.9 Inpatient hospitalization should be limited to the time necessary for stabilization. Adequate community resources and supports are critical for facilitating discharge and helping the person to return to life outside of the hospital.

1.10 A general hospital psychiatric unit should strive to achieve cost-effective and efficient management of human and other resources consistent with the provision of high-quality psychiatric services to the community it serves.

1.11 To ensure that the general hospital is properly serving the population in need of psychiatric services, continuing research on the needs of this population, quality assurance and program evaluation should be explicit components of program management.

Quality assurance programs, including both external audit and ongoing internal monitoring processes, are essential in ensuring good patient care and fostering program development. Quality assurance should be integrated into the ongoing programs and procedures of the department so that regular or continuous evaluation is provided. Staff should receive periodic feedback from both external and internal audits or evaluation processes.

Quality assurance, program evaluation and research need to be looked at from a multidisciplinary stand with a longitudinal perspective cutting across community, outpatient and inpatient services. Principles of quality assurance and program evaluation should guide the development and implementation of services.

2. PATIENT POPULATION

General field experience has shown that there has been an explosion in the demand for mental health services in general hospitals. Recent utilization surveys show that in some acute care hospitals, generally associated with a high degree of sophisticated technology, a large number of beds are occupied by persons with mental health problems or related illnesses. Other studies show that half of the people who have a primary psychiatric diagnosis and need inpatient care are admitted to general hospitals that do not have a psychiatric program.

The escalation in demand is due to many factors. Adoption of the principle of deinstitutionalization has led to the discharge of many inpatients and closure of a large proportion of beds in many provincial psychiatric hospitals. Former inpatients and many newly diagnosed patients are now being treated in the community, with the general hospital providing many of the services that they require. Although prejudices and stereotypes of mental illness still exist, there is now greater acknowledgement in the general hospital that social and

psychological problems merit investigation and treatment, whether the problems are the prime reason for seeking help or whether they accompany physical trauma, such as those arising from suicide attempts, substance abuse or severe burns. There is also a greater understanding of the psychological components of many physical illnesses. This more holistic approach to care increases the demand for mental health services. Increasingly, general hospitals are dealing with ongoing disability problems.

The patient mix of any program will be defined by the catchment area but may contain any or all of the following;

- persons with personality disorders in crisis
- substance abusers
- young adults experiencing an initial psychotic episode
- recurrent psychotic episodes in chronically disabled adults
- elderly persons with psychiatric illnesses
- persons with conditions such as depression, which are reactive to environmental stresses.

There are many positive aspects to providing psychiatric care in the general hospital. By being offered treatment in the community in which they live, patients can maintain ties with family and friends and the unit of treatment can include other persons who are significant in the patient's life. The general hospital is an integral part of the community, and mental health treatment at the hospital can therefore be viewed as a normal part of care for the person suffering from mental or physical illness. Close liaison can be maintained with the family physician and other professionals who have cared for the patient. The availability of medical diagnostic personnel and equipment can enhance accurate medical assessment and treatment, and optimum resources are normally available in such areas as dietetics, rehabilitation medicine and pharmacy services.

In most jurisdictions today, there is a commitment to deliver services on an outpatient basis whenever possible. However, inpatient care will always be needed for assessment and intervention, and for treatment of recurrent episodes of acute illness and acute problems arising from residual disabilities.[2]

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[2] See C.2 "Inpatient Services"

Selection of Hospital

In areas served by both psychiatric hospitals and general hospitals with psychiatric units, there is sometimes a lack of clarity about whether a patient should go to a psychiatric hospital or to a general hospital. To a large extent determination for individual cases will be based on local referral patterns and special interests of clinicians. Some general statements may be helpful, although these will not fit all parts of the country:

- Patients with medical and surgical problems, including those with psychiatric disturbances following surgery, dialysis or other treatment, should be treated in the general hospital.

- Patients whose conditions are expected to improve with short-term treatment or hospitalization with the prospect of early stabilization, should go to the general hospital with a psychiatric service.

- Patients whose conditions are the subject of study by a specialized team or clinician, for example a patient with an eating disorder, should go to the hospital of that specialization.

- Patients who are expected to require the more extensive and long-term psychiatric and accommodation resources of a psychiatric hospital should go to the psychiatric hospital.

Provincial ministries of health should draw up specific guidelines which are appropriate to their own jurisdictions.

Services to the Severely Disabled

In addition to services for the acutely ill, services must be provided for the subgroup of severely disabled psychiatric patients who often need a stable supportive environment and engagement in meaningful activity over a long period of time.

Such patients will not be well served by referral to "flow through" time-limited programs which teach the acquisition of skills and then require the patients to leave the program and re-enter some more "normal" environment. Patients may do well while in the program but then do poorly when transferred into competitive employment or more heterogeneous and demanding social settings. Nor will they be well served by referral to one time-limited program after another. Such

management will result in relapses, dislocation and readmission to hospital care.

The goals of programs serving these patients must be clearly defined. Day centres, activity programs and drop-in centres, which may be hospital- and community-based and which are not time-limited, may be necessary to meet the need for stable, accepting environments, with activity and social contact. The success of such programs should be measured by how well patients do while attending, not how well they do after being made to leave the program.

3. REGIONAL AND LOCAL PLANNING CONSIDERATIONS

In large urban centres, acute care hospitals generally provide a full array of inpatient, outpatient, partial-hospitalization and consultation/liaison psychiatric services. The substantial increase in the number of hospitals providing these services implies an increased potential for overlapping and duplication of programs which reinforces the need to minimize duplication by planning and coordination of services. The services provided by the general hospital will vary by region, but they will invariably be one component of a larger continuum or "network" of services. The relationship of non-hospital-based services to hospital services should be considered at an early planning stage.

The network approach to program coordination and service delivery requires that the hospital be an active participant in the development of necessary mechanisms and processes that promote coordination and integration of services. Whether a hospital is a prime initiator or a collaborative participant will depend on the philosophy of service delivery in a particular region or jurisdiction.

In urban centres where several hospitals provide comprehensive psychiatric services, duplication of specialized services should be avoided. Planning should ensure both coordination of programs between hospitals and appropriate linkage of hospital-based services with other non-hospital-based services. Relationships of in-hospital programs to each other should be analyzed in depth (e.g. inpatient to outpatient to day hospital; inpatient to emergency services). However, the main and overall objective should be to assist patients to receive the services they need.

3.1 Planning, Coordination Issues

Emerging themes in planning the coordination and integration of psychiatric and other services include:

- priority of service for high-risk patients and groups
- local participation and local program development and delivery
- coordination of all agencies that provide mental health services at both local and regional levels
- development of mental health advisory committees to promote understanding and cooperation[3]
- recognition that community programs, psychiatric hospitals and general hospital-based psychiatric services comprise primary elements in the "continuum of services"
- ongoing research and evaluation to determine need for, and effectiveness of, programs
- promotion of professional standards and highly qualified staff, both in the areas of direct service delivery and in key administrative and planning positions.

3.2 Regional Planning

In some areas government departments and other planning bodies may require particular local planning and coordination processes related to psychiatric units. Planning committees may be developed at local, regional and provincial levels to provide input. Hospitals have an important role to play in planning dialogue at all levels including in-hospital planning.

In all regions, hospital providers should establish close educational and working relationships with other major providers and community groups. In planning and delivering mental health care services for a region, the following tasks will need to be undertaken:

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[3] See: Metropolitan Mental Health Planning Board of Halifax-Dartmouth. Health and Welfare Canada

- identify the area's target population and needs for general care, crisis intervention, ongoing and specialized care programs.

3.3 Local and Community Planning

In planning and delivering mental health services at the local level, planners must ensure that services are not duplicated and that gaps in services are identified and covered (see 3.1 on p.14).

All disciplines from the general hospital psychiatric team can offer their expertise and experience to social agencies residences, voluntary organizations and self-help groups in an ongoing process of liaison and consultation. They can provide expert help at times of crisis to give guidance on individual patient management, for example for disturbed elderly persons, which may allow the person to be treated in the community.

Within the hospital, members of the psychiatric unit may be called on to provide consultation to emergency and to medical/surgical wards for example to a former patient in psychiatry, who may benefit from being seen by the primary caregiver from the psychiatric unit. This caregiver can also provide information about the patient's history and advise on management and treatment. Staff from psychiatric units may be involved in discussions around discharge from medical units for example when it is uncertain that a patient can live at home independently.

General Hospital Services

The traditional role of the hospital as the centre of treatment of the acutely ill will apply as much to persons seeking treatment for acute psychiatric illness as it does to persons suffering from other forms of acute illness. As previously stated, the extent to which the hospital provides these services will depend on other resources in the community. However, the general hospital will need to provide inpatient services, partial hospitalization programs and certain identified outpatient programs as described in Section C.

Education and Consultation

Hospital administration should encourage and foster close collaborative working relationships between hospital staff and other providers of mental health services in the community in order to ensure that the needs of psychiatric patients are being met. Provision of advice and education should be a two-way flow. The hospital can provide training for students that could range from one or more student field

placements a year to clinical seminars. In-hospital education programs can benefit from involvement of community experts by presenting information on topics such as discharge planning, interviewing techniques and alcohol and drug programs in the community. Hospitals can also give seminars, hold "Clinical Days" and otherwise provide information to general practitioners and other community practitioners. Material may cover topics such as recent research findings, recent advances in clinical techniques, and advice on specific problems such as identification of a suicidal patient.

4. ASSESSMENT

Comprehensive assessment provides the knowledge base from which the patient's management and treatment plan is developed. Assessment is a process which goes considerably beyond diagnostic procedures.

Assessment must include: a comprehensive review of the patient's biological function, including a medical history and physical examination;[4] a review of psychological function, including a psychiatric history and examination with emphasis on mental state and cognitive functions; and a variety of occupational and social investigations. A social history should be taken and assessment made of the patient's current domestic situation, social network and resources, where possible with corroborative information. Where appropriate, social and occupational function should be assessed, using standardized techniques to cover such matters as ability for self-care, household chores and daily living skills.

Discharge planning is a process which begins at the assessment stage and continues throughout treatment. An extensive knowledge of community resources and facilities is essential for effective discharge planning and for consultation and liaison, both within and outside of the hospital.

Ideally, and particularly with older patients, assessment should begin in the home, for the home visit provides a unique opportunity to gather information about the patient. The home's location, condition and amenities, together with the degree of family support available, all have a bearing on the management and treatment plan. Outpatient assessment is less threatening and disruptive of patients' lives than inpatient assessment. However, it is often necessary to admit patients

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[4] Increasingly advanced imaging techniques are being used in diagnostic procedures.

in order to carry out procedures with security and adequate observation. Indeed, assessment may be the prime reason for admitting a patient to hospital.

The assessment should be carried out by specialists in relevant fields. Their joint observations should be compiled into a single assessment report. The treatment plan, based on the assessment information, must be goal-oriented and should include planning for post-discharge care. Assessment should be a continuing process allowing for new information to augment the initial assessment and management conclusions.

5. HOSPITAL-BASED PROGRAMS AND THERAPIES

Psychiatric treatments and psychotherapies are constantly evolving in response to ongoing research and changing models of clinical practice; hence this description of hospital programs and therapies is necessarily general and should not be considered exhaustive. The general hospital psychiatric service must define and delimit, in consultation with other community service providers, the scope of treatment modalities offered by the hospital in order to ensure that a full range of treatments is available within the regional mental health system.

The general hospital psychiatric service will typically treat persons suffering from multiple severe problems at the same time. Selection of treatment modalities will be based on a comprehensive assessment of patient needs, and appropriate treatment will usually require different treatment modalities simultaneously or in sequence. In order to make the full range of treatment modalities available, it is necessary to have the services of several disciplines, which are referred to in Section 6.

Problem areas requiring treatment or referral will include:

- Symptoms of major psychiatric disorders (e.g. psychosis or major depression) requiring medication or other treatment.

- Other concurrent medical problems, treated by appropriate referral to other departments or services in hospital or community.

- Problems in living, requiring individual psychotherapy, counselling, education and skill development.

- Social and interpersonal problems, requiring group therapy or family therapy.

- Skill deficits or residual disabilities, requiring rehabilitation services, job retraining, community program placement, etc.

- Lack of community resources and supports, requiring referral and bridging services.

- Other specific symptoms requiring specific target treatment modalities (e.g. behaviour therapy).

6. PERSONNEL

Staffing Establishment and Coverage

Multidisciplinary staffing is necessary to provide adequate breadth of treatment. The size and composition of the mental health team will vary but may include psychiatrists, psychologists, nurses, social workers, occupational therapists and appropriate community professionals, such as public health nurses, to ensure continuity of care. Each of these professionals should have fully developed assessment and diagnostic skills, as well as direct patient care and treatment skills. They should have knowledge of community resources, and the capacity to access the network of supporting social services.

Programs should be implemented by each unit of the service, according to the identified needs of the patients to be served. This will determine the staff expertise required. The mix and deployment should be decided by the clinical directors of the units in consultation with the heads of the various professions.

Workload measurement systems guidelines may be useful when planning psychiatric programs.

While the responsibility for the service lies with the clinical director, who should be a psychiatrist, no one person or profession should have absolute control over the functioning of the team members. Policies must be clearly defined regarding the relationship, duties and responsibilities of all team members of the mental health staff. Any member of the multidisciplinary team may function as the administrative leader but he or she should be chosen primarily for managerial skills. Every patient should be assigned a primary therapist on the treatment team. The primary therapist should be responsible for coordinating the treatment plan for that patient.

Depending on personal ability and training, any member of the treatment team may become involved in patient assessment, program design, development and evaluation; psychotherapy, group therapy, family therapy and behaviour therapy; research; in-service education; crisis intervention; and case management.

In psychiatric settings, staff in every discipline should have specialized skills and experience in clinical work with psychiatric patients. In order to handle distressed patients competently, they should also have qualities of personal stability, concern for patients and good communication skills. Staff members who are inexperienced and clinically untrained should not be placed in positions of responsibility for patient care, but should work under the supervision of experienced practitioners. To ensure the continued provision of high-quality care, each profession requires time for administration, charting and professional development, as well as adequate support services.

Service Directors

Service directors should coordinate services within the multidisciplinary team, be responsible for the overall administrative operation of the service in keeping with the hospital's philosophy and policies, and be responsible for service evaluation with respect to effectiveness and efficiency. Service directors should possess broad evaluation and consultative skills, and, when appropriate, may assume a certain amount of clinical involvement and responsibilities.

Staff Training and Qualifications

6.1 Medical

Clinical Director

A certified psychiatrist should be responsible for the direction and supervision of a general hospital psychiatric service. This person would be responsible for all clinical treatment policies and practices and for supervising all medical staff having clinical involvement with service, including the private practitioners and, where local circumstances require, the general or family physician with admitting, attending or treatment privileges. In most cases, the clinical director should also be responsible for administrative direction and have further training experience and skills in management and administration.

Depending on patient load, the director should be assisted by other medical staff. The staff should include attending psychiatrists, and, if the hospital is a teaching facility, interns and residents working under

appropriate supervision. Where possible the facility will want several psychiatrists working together to deliver a service. It is assumed that the psychiatrist will also carry out activities in the other related service programs: i.e. outpatient, partial hospitalization, emergency and consultation/liaison. This assumption may not always apply (e.g. where inpatient staff are fully committed to research or teaching activities). There is little data to indicate appropriate staffing ratios for other services such as outpatient service.

Individuals practising psychiatry should possess specialist qualifications with the Royal College of Physicians and Surgeons of Canada or equivalent. As they will function in close proximity to their medical and surgical colleagues, they should have a demonstrated interest and special training in consultation and liaison techniques, (see page 63). All medical staff must be registered with the official provincial licensing body.

Other Physicians

Besides participating in the functions listed above, and according to their training and ability, physicians are responsible for all the medical treatment of the service and must be competent in handling medical psychiatric emergencies. Each physician providing coverage should have training or experience in caring for individuals with psychiatric or mental disorders and should be familiar with the patients and programs in the unit.

6.2 Nursing

Nurses[5] should have professional qualifications that meet appropriate provincial standards and should be actively registered with the appropriate provincial body. This includes both the Registered Psychiatric Nurse (R.P.N.) and the Registered Nurse (R.N.). It is desirable that all diploma nursing personnel have post-basic training in psychiatry. Where there are Registered Nursing Assistants or other assistant staff, they should also have appropriate psychiatric training.

It is desirable that nurses in senior positions have advanced preparation in nursing or a related field. Community mental health nurses should have a post-basic course that emphasizes counselling skills and principles of community networking.

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[5] Nurse includes registered nurse and registered psychiatric nurse as licensed in accordance with appropriate provincial legislation.

All nurses should have proven skills in clinical, managerial, education and consultation techniques. They should have the theoretical knowledge and ability to perform all aspects of nursing care, including the application of psychiatric nursing principles. Communication, interpersonal, crisis intervention, and leadership skills are required as well as the ability to function within a multidisciplinary team structure.

A large percentage of nursing time is spent in the delivery of direct clinical services. In the remaining time, as members of a multidisciplinary team, nurses should participate in the team's assessment of the patient in order to plan, manage and evaluate individual treatment programs of work training, daily living skills, reality orientation, social-recreational activities, individual and group counselling, physical health needs, medication regimes and discharge.

For short-term, active-intensive inpatient psychiatric treatment, suggested overall guidelines for nursing coverage should be between 4 and 7.5 paid hours per patient-day. This time range will vary with patient mix and levels of required observation programs and other factors. Increasingly, where possible, use of workload measurement systems should be made to determine staffing requirements.

6.3 Clinical Psychology

Clinical psychologists should be graduates of accredited university programs in clinical psychology, and must meet appropriate provincial standards for registration (in most jurisdictions the minimum requirement is the Ph.D., a one-year full-time predoctoral clinical internship and additional postdoctoral supervised clinical experience).

Hospital departments of psychology increasingly contribute consultative, research and treatment expertise to other departments of the hospital in addition to services provided to psychiatric patients and programs. The training of clinical psychologists prepares them for a variety of health-care roles including diagnosis (cognitive, personality and neuropsychological assessment), treatment (individual psychotherapy, group and family therapy, pain management, biofeedback, crisis intervention), research design, data analysis, program planning and evaluation techniques.

Psychologists have particular responsibility for ensuring that psychological tests are utilized in compliance with all relevant professional standards; this includes supervision of psychological assistants, secure and confidential storage of test data, valid interpretation and accurate communication of test results to patients.

As a general rule, there should be one full-time clinical psychologist for each treatment team. This will vary depending on local conditions. For example, in small hospitals or sparsely populated areas, several programs may share a consulting psychologist. In large teaching hospitals, however, a larger number of psychologists may be required by services with significant research and teaching components.

6.4 Social Work

Social work staff of a psychiatric unit should be trained and qualified to participate in the management and treatment of psychiatric patients. This normally requires qualification at the M.S.W. level (or M.S.W. equivalent) from a recognized university. Specific clinical training, either in the course of their program or in supervised post-graduate clinical experience, is required. Senior or consulting social workers should be qualified at the M.S.W. level. In some settings, social workers with other than M.S.W. qualification may work with inpatients under the supervision of a qualified M.S.W.

Social workers participate in the multidisciplinary assessment of the patient at the point of entry into the system, in order to help determine possible family or social precipitating factors of the illness or symptoms and to contribute to decision-making about management or treatment and discharge. While social workers are fully participating treatment team members at all stages of patient care, they usually take particular responsibility for liaising between the team and the patient's social environment. Key aspects of this role are crisis intervention with the patient and family and liaison with key figures in the patient's life, whether family, friends, neighbours or professionals.

The social worker's collaborative relationships with team members and agencies in the community assist patients to gain access to needed resources and services, such as social assistance, accommodation or employment.

Depending on personal ability and special training, the social worker may also take responsibility for program design, research, in-service education and teaching in other departments or outside the hospital, as well as for individual, marital, family and group therapy.

It is difficult for a hospital to determine required numbers of social work staff because social workers are expected to perform a wide variety of functions. However, depending on geographic and demographic factors, range of services provided, size of unit and types of illness treated, there should be at least one full-time social worker available to each treatment team.

6.5 Occupational Therapy

Occupational therapists should be graduates from a recognized university program or equivalent, be eligible for national registration and meet appropriate provincial standards. They should also have training in adult psychiatric services, either in the course of their education or in post-graduate clinical experience.

The practice of occupational therapy includes, but is not limited to, consultation and evaluation to assess the physical, mental, social or developmental capabilities of the patient. A planned occupational therapy program should use functional activities to maintain and improve existing performance in self-care, work and leisure skills, as well as to promote and develop latent abilities.

Occupational therapists also contribute to the overall diagnosis and assessment process as well as to designing programs of activities for individual and/or groups of psychiatric patients according to functional program needs. Modalities frequently used are: activities of daily living and self-care; activities of a non-verbal, projective and creative nature; and activities to facilitate the development and use of vocational, recreational, communication, interpersonal and social skills.

Occupational therapists frequently assess the patient's home or employment situation prior to discharge when functioning is precarious, thus performing a vital role in preparing patients for re-entry into the community.

6.6 Other Staff

The hospital's rehabilitation personnel may include recreation therapists, community workers and specialized therapies such as art, music or dance. Rehabilitation personnel should qualify for membership in their respective professional associations, where these exist, and have relevant training and experience. Chaplaincy service workers should be available. Appropriately trained volunteers may be used to augment staff and enrich programs and services. Legal aid and "ombudsman services"[6], as required by provincial statute, should be available to the patient.

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6 See D.3 "Patient's Rights"

6.7 Orientation and Continuing Education

People working in this area need orientation over and above basic training. All members of the treatment team should update their skills on a continuing basis by attending case conferences, seminars, post-graduate courses and lectures. There should be an in-service education program, preferably directed by a designated person who would be responsible for structuring courses and engaging appropriate persons with expertise in each discipline. Staff should have ready access to reference material and library services.

As resources permit, staff should be encouraged to participate in research and training activities offered by other centres, universities, teaching hospitals and by the parent hospital.

6.8 Teaching Role

Education of students, under the supervision of a staff member of the appropriate discipline, should be encouraged within such an organized program.

6.9 Research and Evaluation

All members of the treatment team should be prepared if not to carry out research projects, then at least to cooperate with other investigators. The appropriate collection of longitudinal data from all of the various components of the psychiatric service will facilitate program evaluation, assessment of individual treatment modalities in terms of effectiveness and efficiency, and assessment of the potential or inhibiting effects of one treatment on others. Such information is invaluable in planning treatment programs.

C. HOSPITAL SERVICES

1. PSYCHIATRIC EMERGENCY SERVICES

In most communities emergency services[7] of general hospitals are important points of entry into the system for psychiatric patients. Traditionally, emergency services are available on a 24-hour basis and are accessible to patients at times when other community services are often not in operation - after hours or on public holidays - or when other services are full. Increasingly in times of constraint, the system of delivery of care, particularly in psychiatry, becomes emergency driven.

The level of development and degree of sophistication of emergency psychiatric services will vary, depending on the nature of the community and available resources. However, the purpose of such services is to provide specialist advice on the evaluation and management of acute disturbances of mental state and behaviour.

An effective program provides services that include:

- full assessment of the patient's mental, physical and social status[8], including assessment of dangerousness
- emergency treatment and initiation of ongoing treatment
- a back-up to other institutional and community resources

Emergency departments with these services are frequently in a pivotal position. Where the capacity exists to keep patients for brief periods of one to five days, longer hospitalizations may be averted. This is particularly true when it is then possible to refer patients to specialized treatment through other services at the hospital or in the community.

A major part of assessment in the emergency service should focus on the adaptive resources of the patient and the community.

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7 Guidelines on Emergency Units in Hospitals, Report of the Working Group on Special Services in Hospitals, Health Services Directorate, Department of National Health and Welfare, 1981

8 See Section B.4 "Assessment"

1.1 Patient Population

Increasing numbers of mentally ill persons with varying combinations of physical, psychological, social and economic problems are turning to the general hospital for assistance. Some patients will require immediate medical or surgical intervention and some immediate psychiatric intervention, while others can be redirected on a non-emergency basis to various follow-up services.

Common situations that arise include: physical problems such as damage arising from suicide attempts; the treatment of drug toxicities and reactions; the differentiation of neurological problems presenting with disturbances of behaviour or mental status, and otherwise unsuspected physical problems aggravating a longstanding psychiatric condition.

Non-physical psychiatric emergencies include the management of the suicidal or otherwise dangerous patient, acute psychotic episodes, exacerbations of chronic psychoses either relating to non-drug compliance or situational pressures, substance abuse and situational crises.

Many of these patients can be disruptive and unpopular. In consequence, they risk being accorded inadequate attention.

1.2 Program Allocation and Relationships

Comprehensive Planning

All communities must have a 24-hour response capability to psychiatric emergencies. Regional authorities must plan an organized response to psychiatric emergencies and clearly define the roles and responsibilities of community services. Emergency departments should foster close links with other institutional and community resources.

There will be a considerable variation in the extent to which emergency services are provided. Not all general hospitals have a department of psychiatry. Some see themselves in an "adjunctive" role, i.e. supportive of the mental hospital in the region, not dealing with the more disturbed, chronic or acting-out patients, and without a clear catchment area for psychiatric patients. Other general hospitals with a psychiatric department see themselves in a "pivotal" role, i.e. central in a given community, with a defined catchment area and with the expectation of dealing with the majority of psychiatric problems that arise within that community; they see themselves reaching out into the

community and dealing with the majority of emergencies that arise there[9].

In all cases, however, whatever the role and expectation, regional authorities must plan a collective response to psychiatric emergencies and must clearly define the roles and responsibilities of the hospital and its relationship with existing community services. There is a need to recognize levels of psychiatric emergency service among the hospitals of a given region and to plan an emergency service continuum in the context of planning regional resources.

It is neither expected nor desirable that all persons requiring emergency psychiatric care be treated in hospital emergency departments. Particularly in large urban centres, emergency response systems should be developed in the community to intervene as early as possible and preferably to deal with the situation without hospital involvement. In some communities, these services may extend outward from the hospital by way of a crisis intervention team. Alternatively, such a team may originate within the community itself. These systems are expected to respond rapidly to emergencies that arise within the community. One model with an extensive network of services is provided by the Greater Vancouver Mental Health Services (see Appendix III).

Whether based on an outreach program or on a service response arising in the community itself, emergency management of the patient will be of limited value unless special support services are available, such as emergency boarding home placements and highly responsive aftercare services.

Whatever the system, all persons involved with the provision of emergency psychiatric care, including ambulance services and law enforcement agencies, must be thoroughly familiar with hospital- and community-based services.

Response to Psychiatric Emergencies

All general hospitals must be able to respond, in some measure, to psychiatric emergencies on a 24-hour basis. The level of response will vary from a minimum of someone on staff thoroughly familiar with community services and able to re-direct calls, to a comprehensive specialized psychiatric emergency service including a psychiatric

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9 See Section B.3 "Regional and Local Planning Considerations"

assessment unit with a capacity for treatment and further assessment over several days.

The level of emergency response provided at the hospital will depend to a large extent on the psychiatric services available at that hospital.

There are three levels of general hospitals providing psychiatric care, each with varying roles.

(a) General hospitals with no psychiatric beds. These may provide initial, general practitioner or psychiatric assessment and care in the emergency unit. At a minimum, such hospitals will provide comprehensive information to incoming calls and should also be able, in a crisis, to admit a patient to a medical bed.

(b) General hospitals with designated psychiatry beds. These provide either a direct or consultation service to the hospital's emergency department. The role of these hospitals is to provide speciality psychiatric assessment and intervention in a wide range of acute psychiatric illnesses, and to establish an intimate liaison with community resources.

(c) General hospitals with psychiatric units which are affiliated with a university department of psychiatry. The role of these teaching hospitals is to provide the highest level of psychiatric assessment/treatment expertise available in a number of specialized areas, including the development of a specialized emergency psychiatric service. It is likely that such hospitals, situated in major urban centres, will have emergency psychiatric assessment units associated with the emergency department and that these units will have their own dedicated space and staff.

1.3 Programs and Policies*

Medical Services

Given the complexity of many psychiatric referrals to emergency departments, and a high incidence of associated physical disorders, it is essential that a wide range of medical services be available to the psychiatric staff. Close relationships must be developed with other hospital departments.

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* See also Appendix V

Such relationships will be more readily promoted if the psychiatric staff are as available to the emergency department and to emergencies in other parts of the hospital as are their colleagues in other disciplines. It is of particular value if the crisis intervention personnel in the emergency psychiatric unit are on call for crises that may develop in any other part of the hospital.

Medical Direction

Medical direction and supervision of emergency psychiatric services should be the responsibility of a psychiatrist. When a psychiatrist is not available, the physician in charge of the emergency service should be responsible for the direct supervision of emergency psychiatric services and a responsible physician, preferably a psychiatrist, should be available for telephone consultation and within travelling distance at all times.

Policies and Procedures

Objectives of the emergency services should be written and should include descriptions of the types of services provided. Specific policies regarding observation, detention and management of patients must be established in conformity with provincial legislation. Because of the emergency nature of the service, protocols for the management of excited or violent patients must be developed.[10]

Policies must clearly define the duties and responsibilities of all members of staff who handle psychiatric emergencies. When psychiatric services are integrated into the general emergency services of the hospital and when psychiatric staff may only be "on call" for certain hours of the day, then the general emergency staff must have precise instructions regarding admissions, call back and referral procedures.

Discharge Planning

As part of the interface between the hospital and other community resources, it is important that the emergency psychiatric staff be thoroughly familiar with other community resources and establish a close liaison with them. Whenever possible, personnel from community resources to be utilized after discharge should meet with the patient in the hospital and take part in the discharge planning. Patient compliance is considerably bolstered by such measures.

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10 See Section D.2 "The Potentially Aggressive Patient"

Follow-up may be provided by family physicians, psychiatrists or other mental health professionals. Housing and financial support are essential elements in discharge planning and must be considered before discharge of the patient back into the community.

1.4 Psychiatric Assessment Units

The disposition of patients from the emergency department is frequently a problem. Patients may not be immediately ready for discharge and yet it may be that admission to an inpatient service could be avoided if they were observed for a period somewhat longer than is usual in the emergency department. Some hospitals have made available a small ward or holding unit that can be used for this purpose, both for the physically and psychiatrically ill patient. Such a ward is appropriate for patients with minor orthopedic injuries, head injuries requiring supervision, recovery from suicide attempts and brief crisis interventions in the psychiatric patient. However, some patients will require more privacy and secure handling than this type of unit can provide (see section 1.6).

In some hospitals, it is possible to have specialized psychiatric assessment units in addition to emergency, outpatient and inpatient services. Such units should provide the following services, generally within a two- to five-day period.

(1) More detailed evaluation of the patient's needs.

(2) More complex discharge planning.

(3) Effective back-up to, and liaison with, other community resources in crisis situations.

(4) Initiation of treatment.

(5) Caring for the patient until inpatient placement or the required community resources for follow-up become available.

Psychiatric assessment units should be available in all hospitals having extensive psychiatric services. It should be anticipated that 50 per cent of the patients managed in such units will be discharged back into the community within two to five days and even those who require inpatient transfer will be sufficiently assessed to ensure the most appropriate referral.

1.5 Personnel

Ideally, senior or experienced clinical staff should be available to the emergency service. Whether or not this type of expertise is available, all staff who must deal with emergencies should be trained in clinical approaches and methods for controlling patients who are disturbed and acting out. These approaches and methods include verbal techniques, rapid sedation, physical restraint and dangerousness assessment.[11]

Policies and protocols governing these approaches and methods must be particularly clear and well documented and must include medical and legal implications (including Civil Rights). [12]

Nursing

At least one registered nurse with psychiatric experience should be present at all times to provide emergency coverage. An expanded role for the experienced nurse practitioner in the emergency department should be considered; in particular, experienced nurse practitioners can play an important part in assessment, triage and crisis intervention.

Social Work

The provision of a social worker should be given priority in emergency services. The social worker's role includes formulating a psychosocial assessment, including helping to determine the precipitating factors involved in the patient's attendance at the emergency department, interviewing relatives, and participating in the team's rapid collection of relevant data. The social worker would also intervene in acute situational crises, liaise with the key persons in the patient's life, and facilitate referral to appropriate community resources. The emergency social worker serves as an essential link between the emergency department and the community and he or she should have an extensive knowledge of community resources. There should be a social worker on call during the evening or preferably on a 24-hour basis.

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11 See also Section D.2 : "The Potentially Aggressive Patient"

12 See also Section D.3: "Patient's Rights"

Others

The skills and experience of other persons will often be required and should be available directly or by referral. Support persons could include psychologists, community workers, childcare workers and voluntary workers skilled in selected crisis situations.

1.6 Space Allocation, Utilization and Special Design Features

Most psychiatric emergency patients will enter the system through the hospital's general emergency department[13]. An adequate waiting area is particularly important for emergency psychiatric care, given the nature of distress, the possibility of aggressively disturbed behaviour and the possible presence of patients who are in the midst of substance abuse. Patients must have the space to distance themselves from others; in larger centres, there should be a separate psychiatric waiting area away from the mainstream of activity. Privacy aside, there must be provision for intensive monitoring of activity in the area and staff available and trained to intervene if necessary. All areas must be equipped and supervised to ensure patient and staff security.

In all emergency departments, a secure[14] room should be available for the management of the more seriously disturbed and acting-out patient. This room should have an individual visual observation system and be equipped to provide for the careful evaluation of the patient and, when necessary, the institution of rapid sedation techniques. This room should be away from the general waiting area; it should be kept available for its specific purpose and not used for other less urgent situations.

Given the nature of the psychiatric examination, interview rooms large enough to allow family interviews, with good privacy and emergency call systems, must be available.

1.7 Teaching and Research

The emergency department, and in particular the specialized emergency department, presents an important opportunity for teaching and

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13 See also Guidelines on Emergency Units in Hospitals, Report of the Working Group on Special Services in Hospitals, Health Services Directorate, Department of National Health and Welfare, 1981

14 A room that minimizes the opportunity for self-injury and/or injury to others

research. While many aspects of psychiatric care can be taught elsewhere, those relating to the assessment and management of emergency psychiatric patients can often be more effectively taught in the emergency department. Such topics might include techniques of rapid data collection, verbal and non-verbal techniques in the management of the acting-out patient, assessment of suicidal and hostile behaviour and dangerousness, medical and legal responsibilities, development of a knowledge of community resources and how to relate to them.

1.8 Special Considerations in Emergency Psychiatric Care

The Elderly Patient

Emergency situations involving the elderly arise both in the hospital and in the community. Some clinical characteristics, differentiating the elderly from other patient groups, have an impact on the provision of services. In particular, older patients are often reluctant to recognize the need for, and are unwilling to cooperate with, psychiatric intervention. As a consequence, a disproportionately large number arrive at the emergency department of the general hospital in crisis and with varied clinical presentations and may require consultation from one or more of a number of specialists such as geriatricians, geriatric psychiatrists and others.

While the majority of patients presenting as emergencies have functional illness or chronic organic brain syndrome, underlying physical illness causing or exacerbating psychiatric symptoms occurs in approximately 25 per cent of such cases and detailed physical workup is essential in the psychogeriatric patient.

Cognitively impaired patients often become the focus of a crisis situation because of the loss of an environmental support that was crucial to the patient's functioning. Intervention in the community may compensate for the loss of such a support and keep the patient out of the hospital.

The Forensic Patient

It is often a matter of chance whether psychiatric patients who find themselves in conflict with the law are brought to the emergency department of a hospital rather than to jail. In either event, there may be diversion from the criminal justice to the mental health system. If patients are brought directly to emergency psychiatric services, they will be cared for through the existing response system. If, however,

they are taken first to jail, the decision may yet be made to divert from there to the mental health system. Such diversions are frequently emergent in nature and it is necessary to develop systems for emergency assessment and disposition to treatment services.

In large urban areas, a 24-hour assessment service should be made available through the forensic psychiatry services. In areas where there are more limited resources, the police department should set up an on-call system of area physicians.

Disposition from prison is often a major problem, although such patients usually differ little from other patients with mental health problems who present at the emergency department. The additional procedures and delays in transfer to the health care system often precipitate or aggravate violent and excitable behaviours which then require emergency care. Various models for the transfer of such patients exist and in principle all psychiatric services within the region should be as available to these patients as to those who present through any other gateway. However, since these patients are generally unpopular and are often difficult to manage, confidence within the system should be bolstered by having the most senior and experienced practitioners available to perform the assessment and request placements.

Substance Abuse

The extent of morbidity relating to the disordered use of substances such as alcohol, prescribed and illicit drugs and tobacco need not be restated here. However, general hospitals must constantly strive to maintain a high level of awareness of the problem.[15]

The problems of substance abuse present in a multitude of ways, as follows:

1. Presentation with psychiatric complications. Such patients will present at the emergency department of any inpatient service where common syndromes such as delirium tremens and encephalopathies are seen. Virtually any psychiatric disorder such as schizophrenia may be closely mimicked.

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[15] See also Guidelines on Addiction Services in Hospitals, Report of the Working Group on Special Services in Hospitals, Health Services Directorate, Department of National Health and Welfare, 1984

2. Presentation in association with physical disorders. Accidental injury, gastrointestinal and liver disease should heighten suspicion. Too often histories as recorded indicate only cursory questioning regarding substance abuse. Simple protocols of inquiry should be part of standard procedure.

3. Voluntary requests for intervention. Patients and families will frequently request information quite spontaneously from any department of the hospital and often in the midst of some other crisis. The opportunity of introducing the patient to helping agencies may be lost if staff are not knowledgeable and information is not available.

It is recommended that hospitals maintain a high level of awareness among staff, adopt protocols of inquiry to find otherwise unsuspected cases, and ensure that community resources such as Alcoholics Anonymous, detoxification centres and other programs have an established relationship with the hospital. Wherever possible, referrals to an outside resource should ensure that the patient is either promptly connected through visiting personnel (e.g. Alcoholics Anonymous) or conducted to the resource by hospital staff.

2. INPATIENT SERVICES

A need will always exist for inpatient care. Patients may be admitted for observation, assessment or treatment that can most appropriately be delivered in an inpatient setting. Because of the variety of consultative input available and the opportunities for intensive observation, the inpatient service can also act as a resource to other parts of the psychiatric service by providing a comprehensive assessment of the patient prior to referral to the other services.[16]

Inpatient care should always be considered in relation to the other residential resources that are needed by persons with mental disabilities. The emphasis on prevention, in recent literature and in these guidelines, and on alternatives to inpatient psychiatric admissions, should not be taken to mean that admission should be avoided, at all costs. Rather, where admission cannot be avoided, a comprehensive plan for the patient should be followed. Such a plan will include planning for discharge and identification of community resources for post-discharge care. Admissions undertaken without these perspectives often lead to lengthy hospital stays, functional deterioration and institutional dependency. Admission and discharge decisions derive as

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16 See B.4 "Assessment"

much from availability of resources as from patient condition. Such decisions will depend in part on the availability of hospital services such as outpatient services and day care, but even more on family support and availability of services in the community, including mental health centres, activity centres, group and boarding homes, facilities for long-term care and other resources.

Certain individuals, no matter how well community resources are developed, will experience recurrent acute episodes requiring hospitalization. In such cases, personnel who are treating the patient will generally deal with a combination of acute symptoms and residual disabilities necessitating continuing support in the community. The better the community resources and the better the continuity of care by the same personnel, the more likely it will be that hospitalization can be averted.

While it is clinically advisable, it may not be possible to expect that the same staff can always provide continuity of care across all services. However, continuity must be maintained to the extent that the patient's primary support person in the community provides first hand information at the time of admission, maintains regular supportive contacts with the patient throughout the hospital stay and is intimately involved in discharge planning.

When hospitalization is necessary, the duration of stay may be shortened when such resources as community residential placements, community care teams or family support services are available. Hospitalization should not be seen as an isolated event, but rather as an event in the patient's total continuing care.

Planning for the continuum of care, including discharge planning, should therefore commence at the point of admission and involve the community personnel who will be responsible for treatment after discharge.

It is no longer acceptable that patients in certain diagnostic groups be automatically transferred to psychiatric hospitals. Regardless of etiology or diagnosis, patients with psychiatric disorders who can benefit from general hospital care should be admitted to a general hospital.

General hospitals should be prepared to admit persons with psychiatric diagnoses even when there is no psychiatrist on staff. When this happens, formal contact with a psychiatric service should be established to ensure access to a specialist.

Referrals by general practitioners to the psychiatric care system are most commonly to the general hospital. In most areas of the country, general practitioners provide the major part of the ambulatory care treatment for persons with a psychiatric diagnosis, of which only a small proportion will require inpatient hospital care. In some places the model of the general practitioner as a primary caregiver in psychiatric wards has developed. Where this occurs, treatment plans and discharge decisions usually require approval by a psychiatrist.

2.1 Patient Population

The number of disturbed patients being managed by general hospitals has increased in recent years.[17]

In some centres, a large proportion of those who arrive on a certificate of mental illness suffer from a major psychotic illness, most often schizophrenia, and are often found to be suffering from social isolation and a lack of resources and support in their communities.

Because the inpatient unit is part of a general hospital, the expertise of unit staff should be available to other parts of the hospital to assist in preventive programming, assessment and treatment. Patients requiring psychiatric help may be located in other parts of the hospital, for example, in surgical or intensive care units following suicide attempts, or may have medical conditions with psychiatric involvements, such as some AIDS cases.

In the traditional psychiatric hospital, the size of the patient population allows various groupings of patients by functional level or by diagnostic category for specific treatment programs, thus ensuring a level of service appropriate to the patient. In the general hospital, the size of the patient population does not always allow for this type of grouping. This means that one small group of patients may require widely different types and levels of service. Programming and staffing must reflect this need, and such heterogeneity leads to greatly increased challenges for staff.

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[17] See B.2: "Patient Population"

2.2 Organization and Distribution of Services

Services should be planned within an overall plan for services in the community or region.[18] This is essential if an appropriate range of services is to be made available and duplication of service delivery is to be avoided.[19]

Where several general hospitals are operating in close proximity to each other but are each of insufficient size to generate a psychiatric unit, they should establish a regional unit at one of them. It is important that this unit provide adequate mental health and psychiatric consultation services to the other hospitals in the group.

If a regional unit is not possible, patients with psychiatric disorders should be clustered in a medical unit with at least one nurse with psychiatric experience on each shift.

2.3 Assessment[20]

Although the process and goal of assessment may not differ from assessment in other areas of the psychiatric service (e.g. outpatients), the distinguishing characteristics of inpatient assessments are their setting and intensity. Patients are admitted to inpatient units for assessment when they cannot safely, rapidly or practically be assessed in a less restrictive setting. The inpatient unit provides necessary security (e.g. for the suicidal patient), and the opportunity for around-the-clock observation and consultation among a team of professionals.

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18 See B.3: "Regional and Local Planning Considerations"

19 Specialized services are often started as a result of incentives such as availability of research funds in an area where current public interest is high, e.g. eating disorders. While investigation and treatment of such disorders is important, efforts should be made to avoid duplication of services offered in other units/clinics, and to ensure that resources for essential services required by a larger percentage of the patient community are not jeopardized.

20 See also B.4: "Assessment"

Admission to an inpatient service is also appropriate when some urgent symptomatic treatment is necessary before the patient can be thoroughly assessed. Readily available consultation with other general hospital medical departments is a further advantage, particularly for those patients who find it difficult to keep outpatient appointments with other specialists.

Failure of social support or out-of-hospital care may also necessitate admission to an inpatient service in order to assess the patient's current level of functioning and needs, and to permit structured re-establishment of links with community services.

2.4 Services Provided

The inpatient unit should form part of a continuum of services that care for the needs of the mentally ill. As previously stated, observation and assessment are prime functions of such units. Depending upon local conditions, outpatient departments, private practitioners and family physicians may provide the bulk of treatment following an assessment and consultation by the inpatient team. Thus, in many cases, treatments will be started, but not carried through to completion, in the inpatient unit. Treatment modalities[21] will include a variety of biological interventions, psychosocial therapies, skill development and community resource identification.

For patients in crisis, treatment may be aimed at: containing behavioural disturbances; preventing injury to self and others; stabilizing the mental state to allow full assessment; and treating underlying or coincident physical disorder.

2.5 Patient Load and Bed Requirements

Each hospital must define the parameters of the population it is to serve.[22] Conventional exclusions from the general hospital inpatient psychiatric unit are: specialized residential care, long-term maximum security treatment for seriously disturbed children and adolescents, and other specialized services.

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[21] See also B.5: "Hospital-based Programs and Therapies

[22] See also B.3: "Regional and Local Planning Considerations"

Most hospital stays will be short-term, with an average length of three weeks, but in some areas where other resources are scarce, general hospitals have had to develop programs for medium- and long-term care of up to six months.

In planning new facilities, as a general guideline, the optimum unit size will be 20-25 beds although it is recognized that some existing units are larger. Factors that determine bed capacity will include: community population and needs, other mental health services including outpatient services and the range of available community resources.

A smaller unit (fewer than 20 beds) will be more expensive to maintain. Such a unit may be required in special circumstances, such as in a geographically isolated or rural area, or for a highly selected patient population such as potentially suicidal patients.

2.6 Policies and Procedures

All patient-care policies and procedures developed for the service should be in written form and approved by the Administration and Board of the hospital on the recommendation of the Medical Advisory Committee.[23]

The objectives and general philosophy of the program should be written and should include descriptions of the types of services provided. Written criteria for admission, treatment, management and discharge planning should be developed in accordance with provincial statutes, hospital policy and patient's needs. The criteria should be developed in conjunction with the group of professionals working in the multidisciplinary team. Some of the factors to be taken into consideration would include the severity of the illness, the functional level of the patient, the requirement for essential hospital services, the ability of the patient to use ambulatory services, emergency and crisis requirements and geographic accessibility.

2.6.1 Admission Criteria

A general hospital must decide and have written policies on the types of patients to be admitted. These will include, but not be limited to:

- Age limits for patients.

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23 Appendix V "Administrative Organization, Policies and Procedures"

- Admission of patients abusing alcohol or drugs.

- Admission of certified patients.

- Admission of developmentally handicapped patients.

- Special procedures for admission of patients with infectious diseases (e.g. AIDS).[24]

- Proportion of beds (if any) reserved for special populations (e.g. research projects).

- Other criteria dictated by local conditions.

Positive indicators for inpatient admission include:

- Behaviour dangerous to the person or others beyond that which can be contained by emergency room interventions.

- Need for thorough assessment, with consultative input from other hospital services and health care providers, such as family physicians, when such assessment cannot practically, safely or rapidly be conducted in other settings.

- Need for treatment regimes that cannot safely be carried out in another setting (e.g. drug treatment with risk of side effects, where patients require monitoring).

- Need for medical assessment and treatment of persons with psychiatric disorders.

- Assistance to other community care institutions, such as nursing homes, with ongoing care and management.

- Need for periodic stabilization of chronically ill or disabled persons in order to maintain them in community living.

- Need for provision of short- and long-term social rehabilitation in a structured milieu.

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24 See D.5: "Infectious Diseases"; Guidelines on Infection Control, Isolation and Precaution Techniques, 1986, Bureau of Infection Control, and Health Services Directorate, Department of National Health and Welfare, 1986

2.6.2 Management and Treatment

Policies and procedures should be written to outline the admission and management privileges of the patient's family practitioner or therapist. Such privileges should be subject to review, under the general direction of the Director or Chief of the Department of Psychiatry.

Upon admission, a psychiatrist (or where local circumstances require, a family physician) will be assigned to the case. This physician will be medically responsible for the case, but any member of the multidisciplinary team may serve as case coordinator or primary therapist.[25]

An accurate, current, complete and written clinical record including a description of problem, related interventions and outcomes should be kept for each patient. All staff involved in the care of the patient should have input, but duplication should be avoided. A standardized, computerized, confidential patient record should be considered because it would facilitate coordination between treatment programs, rapid data retrieval, and effective program evaluation. Wherever possible, hospital data-gathering systems should be compatible with provincial data-gathering systems.

2.6.3 Other Policies and Procedures

Policies and procedures are required for special levels of observation (constant, close) and should be written to define levels of care, nursing actions and patient privileges and passes.

Policies are required for the use of restraints and seclusion.

Policies on smoking and safety (e.g. with regard to confused patients with diminished consciousness or impaired orientation, self-destructive patients, etc.) should be clearly defined.

Policies are required to outline emergency response to situations requiring immediate attention (e.g. resuscitation code 99 or 444, etc.).

Policies will need to be established, according to provincial legislation, with regard to patient advocates, patient's rights, etc.[26]

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[25] See also Section B.6: "Personnel"

[26] See D.3: "Patient's Rights"

2.6.4 Discharge

Discharge planning should commence on admission. Sources of care that may be required following discharge must be identified and matched to patient's potential needs. Hospital services such as outpatient and day care services may be appropriate if continuing care is required. The availability of support from friends and family is an important factor in making discharge decisions. Staff should have close links with other services in the community that can provide care if needed, e.g. mental health centres, group and boarding homes, facilities for long-term care and other resources.

2.6.5 Quality Assurance and Evaluation

Continuing quality assurance and periodic evaluation of service programs that include professional appraisal and case audit based on an adequate record and data system should be encouraged.

2.7 Personnel[27]

Inpatient staff must have skills in assessment, treatment and discharge linkage for severely mentally disabled persons. Staff must be capable of: one-to-one assessment, programming, central programming for people at different functional levels, and managing aggressive or otherwise difficult behaviour.[28]

Nursing

The inpatient psychiatric service must provide registered professional nurses[29] coverage on a 24-hour, seven-day-a-week basis. There may in addition be a mixture of nursing staff, including nurses' aides, as required by the patient care needs.

Precise numbers of nursing staff are difficult to specify. Certain factors must be taken into consideration such as patient needs, nursing classification and nursing workload systems, labour force, teams' programs, architectural design and location of the unit.

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27 See B.6: "Personnel"

28 See D.2: "The Potentially Aggressive Patient"

29 Nurse includes registered nurse and registered psychiatric nurse as licensed in accordance with appropriate provincial legislation.

2.8 Space Allocation and Special Design Features

Space requirements for inpatient services will depend on a variety of factors such as:

- patient load and type of population
- staffing requirements
- the services shared with other psychiatric programs such as outpatient and partial hospitalization
- degree of access to shared facilities e.g. conference rooms, sitting areas, reception areas
- structural design, such as planning for a home-like atmosphere
- services and spaces shared with other departments of the general hospital, e.g. housekeeping, dietary, fire and safety, staff locker rooms, canteen services, medical records, etc.
- national, provincial and local building codes and standards.

2.8.1 Location

The principle of normalization should be considered at all times in designing and locating the psychiatric inpatient unit. The unit should be an integral part of the general hospital complex and not added on to the periphery of the hospital. Services such as admitting, laboratory, personnel, clinics and therapies should be as easily accessible to the unit as they are to other units or programs in the hospital. The unit should be close to another medical unit in order to have help readily available in an emergency.

Units should be located at ground level, if possible, preferably close to a park-like environment. To facilitate community interaction and promote as normal a lifestyle as possible for patients, it is recommended that there be easy access to the street. While ease of access to the outside is important, control will be necessary for the safety of some patients, such as persons who are suicidal.

2.8.2 Safety Features

General hospital units will have to deal with most types of psychiatric illness. The physical design of the unit should allow for a selection of treatment areas that offer seclusion and low stimulation for the relatively non-verbal, potentially violent patients, who require a greater degree of supervision and special observation. If the unit cannot provide specialized space, it is essential to have access to an area which would allow patients, who are excited and unmanageable within the normal milieu, to receive the type of treatment they need. Secure rooms and special observation areas should be an unobtrusive part of the total design.

The following general features are recommended:

1. Visual control of corridors from the nursing station; this sometimes requires the use of mirrors.

2. Visual and audible warning at the nursing station when someone leaves or enters the unit. (Fire and building codes preclude the use of locks in many situations).

3. In addition to regulations for dangerous drugs, all substances that could be used for injury to self or others should be kept under lock and key. This includes cleaners, disinfectants and other toxic substances.

4. Areas where smoking is or is not allowed must be clearly defined.

Room Features

1. Where special safety features are required, their design should be as subtle as possible.

2. A double door system from the corridor to the room can be used to restrict patient access to the bathroom when required. The inner door has an observation window with a curtain for privacy. This inner door can be left open when bathroom restriction is not needed.

3. Bathroom and inner doors should be recessed and open outward or have special hardware to permit opening outward in emergencies.

4. Exposed pipes, fixed or removable shower and clothing rods and hooks, etc. should be avoided because they could be used by patients to injure themselves or others.

5. Window drapes and their potentially dangerous brackets and track (see 4, p. 47), are often replaced by venetian blinds enclosed in a double pane window. All curtains and drapes should be fire-proof.

6. Glass in windows should be unbreakable and is usually tempered.

7. Access to open windows should be limited.

8. In multiple-bed rooms, bedside curtains should be hung from ceiling-mounted track rather than the suspended track which can be easily damaged or used by patients for injury to themselves or others.

9. Generally, no special plumbing is required. However, water temperatures should be controlled to avoid scalding.

10. In the one or two rooms designed for the more aggressive/violent patients, loose ceiling tiles should be replaced by a more substantial solid surface.

11. Medical gases, if required, must meet safety standards, and regulations for their use must address the possibility of misuse by patients.

2.8.3 Space and Design Requirements

Layout

Some planners feel that the typical hospital arrangement with central nursing stations is inappropriate for psychiatric patients and prefer to create a "therapeutic milieu" by grouping patient bedrooms around living or lounge spaces to encourage interaction and better simulate a residential environment. Such patient units should have an adequate number of single rooms in order to allow for privacy and freedom from nighttime disturbances. Overall, space requirements will not vary significantly from that of a standard unit. However, the construction of such specialized facilities will be expensive. Consequently, these units should always be planned with possible future uses in mind.

Patient Rooms and Bathrooms

Although some design details may differ, patient rooms in psychiatric units are generally the same size as any other patient room of a general hospital. Facilities for close observation will be required. Room sizes, finishes, inter-relationships of rooms and decor should be designed to respond to the emotional needs of the patients, staff and

public. Each room should have a wash basin. There should be at least one toilet for four patients and one combination tub and shower for every seven patients. Facilities for the handicapped must be considered in bathrooms and other toilet facilities. Tub areas should have sufficient space to enable staff to work around at least three sides of the tub. Wall and floor finishes should be chosen on the basis of cleaning, resistance to damage and therapeutic value (e.g. colour). Installation of television sets in patients' rooms is not recommended as solitary viewing increases withdrawal and decreases the opportunities to mix with other patients and staff.

Primary Activity Areas

In addition to activities carried out in patients' rooms, psychiatric units require a significant amount of space for activities such as individual and group therapy, recreation and occupational activity or therapy, reading and physical recreation. Space requirements will include:

- Rooms suitable for working with families, large and small groups and staff conferences.

- An occupational therapy area with moveable walls that allow maximum use of space and equipment. This space should accommodate large work tables and provide adequate storage for equipment such as typewriters, woodworking material and other materials as recommended by the occupational therapist.

- A rehabilitation kitchen adjoining the occupational therapy area, designed for self-preparation of some meals by patients.

- Lounge areas (separate for patients and staff).

- Hairdressing facilities and equipment (important for patients' self-image).

- A small personal laundry facility and storate unit.

- Adequate interview and office space for all professionals.

- A physical examination/treatment room (one per unit).

- Adequate treatment and recovery accommodation for electroconvulsive therapy. It should provide private, spacious and quiet area for the recovering patient.

In addition, patients will require access to:

- Food services and a dining area.

- A tuck or coffee shop.

Nurses' Station (See also "Layout")

The location of the nurses' station is a very important aspect of planning. It should be located in a central area of the unit. It is vitally important that all patient areas (bedrooms, bathrooms, lounge, etc.) and the unit entrance be in full view of the nursing station. Exit doors should be monitored by alarms or light indicators at the nurses' station. A nursing staff area for records is required. A separate, lockable medication cupboard is essential.

Administrative and Support Areas

The support space allocated to a psychiatric unit should be significantly less than the space allocated to primary activity rooms. A staff locker room is required (if not shared with the rest of the hospital). Office space for professional staff will often be used as interview rooms.

Space will be required for general inpatient services, such as clean and dirty utility rooms, janitor's room. These should be lockable as they contain potentially harmful equipment and substances.

Depending on individual needs and activities of the staff, space may be required for educational and research activities. Audio-visual equipment and teaching aids are required for continuing education, as well as for patients and their support persons' education.

3. PARTIAL HOSPITALIZATION SERVICES

A general hospital which is attempting to provide a comprehensive service for inpatients and outpatients should also consider offering some partial hospitalization programs as part of its diverse pattern of services. The size of these programs will depend on the nature and needs of the catchment area served.

Functions

The functions of partial hospitalization are to:

- avoid hospital admission, shorten inpatient stays and decrease the readmission rate;
- maximize normal living patterns, foster healthy functioning and provide a bridge between the hospital and the community;
- minimize stigma, dependency, disruption to family and social life;
- make diagnostic assessments including special investigations;
- offer symptomatic treatment and monitor medication;
- offer individual, group, marital and family therapy;
- offer crisis intervention or intensification of outpatient treatment;
- provide consultation and share responsibility for difficult-to-manage patients;
- actively engage the patient's family and social network in the treatment;
- provide specialized programs for specific groups of patients, e.g. the elderly, those with eating disorders or affective disorders.

3.1 Services Provided

Partial hospitalization includes day and partial day hospital treatment, day programs, evening programs, night and weekend hospitalization. Day hospitals usually offer a structured psychiatric treatment program, which patients may attend up to five days a week between 8:30 a.m. and 5:00 p.m. Night hospitalization is provided for patients who are working or attending school during the day and returning to the hospital for dinner, participating in evening activities, and sleeping overnight. Some patients may attend evening or weekend programs only.

3.2 Assessment[30]

The patient requires a comprehensive bio-psychosocial assessment, including an assessment of the patient's rehabilitation potential. The assessment should focus more on the patient's strengths than on diagnosis and pathology.

3.3 Treatment

A review of current literature indicates that focussed therapeutic activities, with a problem-solving, structured or behavioural approach, are more helpful for most patients in partial hospitalization than a non-directive or insight-oriented approach. For example, survival skills, social skills or life skills training or desensitization can provide very practical help for some patients. A wide range of treatment modalities should be available.[31]

3.4 Patient Population

Patients selected for partial programs should be sufficiently motivated and organized to be able to attend regularly (or have a caregiver able to ensure regular attendance) and should have enough family or social support to ensure reasonably stable living situations. Even acutely ill patients can be served by partial hospitalization if they have ready access to short-term hospital admission when necessary.

Partial hospitalization programs are more suited to the needs of patients suffering from acute episodes of illness which will ultimately be resolved, than to the needs of those suffering chronic illnesses or conditions. The chronic patient will require more supportive regimes and long-term care than partial hospitalization programs normally provide. Separate day-care programs should be provided in the community to serve the needs of patients who are chronically impaired, non-compliant or non-responsive to treatment or who are socially incompetent.[32]

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30 See also B.4: "Assessment"

31 See also B.5: "Hospital-based Programs and Therapies"

32 See also "Services for the Severely Disabled" Under B.2: "Patient Population"

3.5 Patient Load and Bed Requirements

Frequency of attendance at partial hospitalization programs should be based on therapeutic indications; the regimen should be flexible and individually tailored to fit the needs of each patient. The number of places available for patients will depend on patient load and the resources available in the psychiatric service as a whole. Beds will be required for night and weekend partial hospitalization programs. In special circumstances, for example, for physically incapacitated persons or where electroconvulsive therapy is administered, access to additional beds may be required.

3.6 Program Allocation and Relationships

As partial hospitalization services focus on enhancing normal, healthy functioning, they should ideally be offered in areas that are separate from inpatient facilities. However, some programs may benefit from being associated with the hospital unit, for example where continuity of care for a former inpatient is an important consideration.

Since regular attendance is important, partial hospitalization services should be easily accessible so that patients do not have to travel long distances or live apart from their families. Night and weekend hospital services should similarly be centrally located in the community. Transportation should be arranged for those who cannot otherwise easily attend.

It may be necessary to provide long-term accommodation for patients who cannot return home each night such as out-of-town patients and chronic patients, in the form of group homes, boarding homes, halfway houses or "dormitory inns".[33]

Relationships

The success of partial hospitalization programs depends on maintaining quick and efficient access to any of the facilities or services provided by a fully equipped hospital. Members of each discipline must therefore maintain strong collaborative links with their counterparts in other hospital departments, both within the hospital and between hospitals, so that the services can be accessed with minimum delay. It is important

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[33] Gudeman, J., Shore, M. and Dickey, D., Day Hospitalization Instead of Inpatient Care for Psychiatric Patients, New England Journal of Medicine, 308; pp. 749-753, 1983

that staff working in partial hospitalization programs communicate their philosophy of patient care to other staff throughout the hospital and in other hospitals. They should make clear their rationale for making requests for service or for patient transfers. Partial hospitalization programs should be seen as being responsive to the needs of patients referred from other hospital departments, so that effective reciprocal staff relationships are established and maintained.

Partial hospitalization programs are most effective when they are operated in conjunction with other hospital and community programs. Continuous turnover and smooth flow from one program to another in various combinations of services, for example day hospitalization and outpatient treatment, enhance the efficacy of each approach.

3.7 Program Organization and Policies

Partial hospitalization is cost effective only if the goals of the program are clear and specific, and if there are stringent selection criteria, careful clinical management and active discharge planning.

Clearly defined policies governing admission and transfer of patients to and from partial hospitalization programs to other services should be developed by the treatment team. The goals and criteria for "admission" and "discharge" should be clearly documented and implemented so that there is a smooth flow of patients from one program to another. Protocols for managing excited or violent patients should be developed.[34]

Responsibilities of Staff

Responsibility for overall medical supervision and drug therapy should be carried by a staff psychiatrist.

Each patient should be examined by a physician before admission. Admissions and discharges should be carried out in consultation with the psychiatrist-director, who would usually be in charge of clinical programs. Staff responsibilities should be determined by the needs of the patients, the objectives of the particular program, and the general policies of the hospital. Members of the multidisciplinary team should maintain frequent and effective communication with one another in order to meet the patient's needs appropriately.

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[34] See D.2: "The Potentially Aggressive Patient"

3.8 Personnel[35]

Partial hospitalization programs would normally be staffed by members of a multidisciplinary treatment team with a certified psychiatrist as the clinical director, although any member of the team could function as the program coordinator. Staff members including the clinical director would not necessarily work full time on the partial hospitalization program. Occupational therapists, art therapists and vocational counsellors can play important roles in some partial hospitalization programs, and other personnel with specific professional skills should be selected to meet the patients' needs.

As the success of partial hospitalization depends on maintaining strong community links, it is important to have staff with the skills to work with families and to liaise with community agencies and facilities on behalf of the patient. The skills of occupational therapists to contact employers and supervise work readiness programs would also be valuable. A psychologist who could perform psychological tests, implement a behavioural treatment regime or offer social skills training or desensitization would be an asset to the team.

Staff Allocation for Day Programs

The ratio and disciplinary mix of staff to patients in a day program will depend on the intensity of the day service offered, the type of program and the specificity of patient needs (patient status/load/mix).

Clerical and stenographic services should be available as required. Volunteers can enrich services provided to partially hospitalized patients. They must be supervised by an appropriate member of the multidisciplinary team.

Staff Training and Qualifications

The staff working in partial hospitalization programs need to develop particular skills in crisis intervention techniques, in managing violent or excitable patients, in determining when to intervene in the patient's social environment, and when to arrange hospital admission for a patient whose condition is deteriorating.

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[35] See also B.6: "Personnel"

3.9 Space Allocation, Utilization and Special Design Features

Both day and night hospital services require space components and safety features similar to those listed in the inpatient service guidelines (pp 47-50). There should be adequate locker, toilet, bathing, kitchen and dining facilities in the unit to accommodate patients, as well as a large group room where meetings of all staff and patients can be held periodically. Access to a garden or an open area where patients could relax, socialize and engage in recreation would be desirable. Special design features should reflect the specific kinds of programs being offered and their goals for patient functioning.

All methods of investigation and treatment which are normally available in a hospital should be readily accessible to partially hospitalized patients with the same criteria of operation as for inpatients. Emergency equipment and medication should be available, as on inpatient services.

4. OUTPATIENT PSYCHIATRIC SERVICES

As the pattern of psychiatric care in Canada has swung dramatically away from residential care, the proportion of treatment events taking place on an ambulatory or outpatient basis has increased substantially, to the point where they comprise the majority of treatment offered in Canada.

Outpatient services should be established according to the needs of the community, and the outpatient director and staff should liaise with other providers of mental health services in the community to determine who should provide what services and how these services should be provided. Because the outpatient department is such an important gateway into the psychiatric system, clinical staff must ensure that cases are priorized and allocated to the professional or facility that can provide the most appropriate service.

The management of patients in an outpatient setting can often prevent inpatient admission, which in turn can prevent or minimize disruption of the patient's support system.

Bridging Function

Failure to make the transition from inpatient hospitalization to post-discharge follow-up services is a major reason for visits to emergency services and/or readmission. Outpatient programs perform an important bridging function by making comprehensive services available to former inpatients, especially during the stressful period following discharge,

when they are vulnerable, prone to relapse and may require frequent appointments. Outpatient and inpatient staff should work collaboratively on discharge planning to define the patient's needs and problems.

Location of Services

There are some advantages in locating outpatient psychiatric services in the general hospital. These include enhancing continuity of care, centralizing scarce personnel, better liaison with hospital staff and ready access to other general hospital services. In addition it offers the possibility of enhancing the interface with community-based services.

Outpatient services can also be located in a separate building or in a commercial office or shopping centre. Such a location can improve patient access to services and can help to normalize the patient's situation.

Satellite services could be located in smaller community hospitals.

4.1 Patient Population

The patient population consists of former inpatients, patients receiving outpatient services as their primary treatment source and patients referred to the service for a second opinion or for specialized services.[36]

In recent years as previously noted, there has been a trend towards an increasingly disturbed population in general hospitals, which, in outpatient clinics, results in a large number of patients diagnosed as chronically psychotic or chronically impaired. Such patients frequently do not respond to treatment, are difficult to manage, non-compliant or violent, socially inadequate or incompetent. They are often known to multiple agencies and are heavy users of health and social service systems, demanding treatment on their own terms. Consequently, there is a danger that they may pre-empt services to the exclusion of other patients.[37]

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36 See also B.2: "Patient Population"

37 See also "Services to the Severely Disabled"
Under B.2: "Patient Population" for a description of the type of services these patients require

4.2 Assessment[38]

Careful and comprehensive assessment and appropriate treatment or intervention must be available to patients whose first and sometimes only point of contact with psychiatric services is the outpatient service. All patients receiving long-term outpatient treatment should have regular physical examinations preferably carried out by their family physician. The clinic should be prepared to provide a second opinion on specialized treatment for patients referred by other facilities or by private practitioners. As previously stated, a consultation outpatient team may assess patients in their own homes or in other settings such as a group home.

4.3 Services Provided

A comprehensive outpatient department must have the facilities to care for patients with a wide range of prognoses.

Treatment

All forms of treatment should be available through the outpatient department.[39] Hospital outpatient departments provide the service of non-medical mental health professionals who are remunerated by the institution. The outpatient department may be one of the few places where ambulatory patients can consult or receive treatment from a professional such as a social worker, psychologist or occupational therapist without charge. Patients who require, for example, a social task skills assessment or training should have easy access to these services which are normally available in the hospital. Programs should be aimed at maintaining patients in the community if at all possible. All patients cases should be reviewed by a psychiatrist on admission to the program and again on discharge from the program.

Specialized Clinics

In recent years, there has been an increase in the number of specialized psychiatric clinics in Canada such as those specializing in schizophrenia, eating disorders or forensic psychiatry. This represents a major change in the pattern of service delivery.

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[38] See B.4: "Assessment"

[39] See B.5: "Hospital-based Programs and Therapies"

Specialized clinics are established in the facility for one or more of the following reasons: because of the need for second opinions, the delivery of a specific type of service by a specialist in that particular field; the enhancement of research, teaching and consultation.

Although special clinics for the treatment of alcoholics and substance abusers may be funded under non-health jurisdictions, it can happen that such clinics are located in general hospitals where there is ready access to the hospital medical resources.

Continuity of care must be maintained for the patient receiving these specialized services. Case managers[40] or primary therapists must ensure that the patient continues to receive all other appropriate services and does not get lost in the system when treatment in the specialized clinic comes to an end.

Ongoing Care

Clinics for ongoing care provide long-term treatment to former inpatients and for others who have never been hospitalized and whose long-term needs for acute or chronic care can be met in an outpatient setting. These clinics provide treatment in many different modalities including psychotherapy, medication follow-up and supportive care for the chronically ill.

Flexibility in hours of operation is important. The need for clinics that are scheduled outside of normal work hours should be examined: patients should not have to choose between resuming or maintaining employment and continuing treatment.

Group therapy can be an important aspect of ongoing care. Groups may be structured according to a problem or diagnosis, or may be organized for relatives of patients with a common diagnosis.

Consultation Clinics

Special consultation clinics do not carry a patient caseload but provide support and guidance on management and treatment, including such specialized services as psychological testing, psychosocial assessment and evaluation of rehabilitation potential. By having access to urgent consultations, community caregivers including family physicians and psychiatrists in private practice can continue to carry the main responsibility for treating the patient. This alleviates pressure on the

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40 See Case Management page 67

hospital to provide these treatment services and allows patients to be treated in a non-institutional setting.

Consultation clinics may also provide an outpatient team that assesses and supervises patients in other settings, e.g. an approved group home. This team may also make home visits to assess patients who are in crisis or to advise caregivers on management and disposition.

4.4 Patient Load

The workload of outpatient services will be influenced by the:

- availability and reputation of clinical services;
- specific community needs; post discharge follow-up;
- number of patients treated by private practitioners and other outpatient treatment facilities.

4.5 Program Allocation and Relationships

Maintaining good communication and collaboration with colleagues in other departments helps to prevent duplication of services and minimizes stress. Standardized data gathering and record keeping in the hospital will facilitate easy exchange of information.

Excessive patient loads may reduce the flexibility and availability of staff. However, in order to provide continuity of care, staff should try to see any patient who is in crisis, whom they are currently treating or have treated in the past. If this is not possible, staff should provide relevant information to staff in the unit where the patient is being treated, e.g. emergency or inpatient unit.

The outpatient department of the general hospital is an interface with the hospital and the community. Close reciprocal relationships must therefore be developed with personnel in community agencies such as social services, legal and educational services. Outpatient staff should have a good knowledge of community resources. In addition, staff should seek and cultivate contacts with voluntary groups, self-help groups, community and governmental agencies.

4.6 Program Organization and Policies

The philosophy and principles of outpatient care must be clearly defined and adhered to by administrative and professional staff.

The outpatient department should participate in the hospital's quality assurance and evaluation programs. Policies concerning the relationships, duties and responsibilities of all members of the outpatient staff must be clearly defined. The size of the treatment teams will vary with the patient load, but they should include psychiatrists, nurses, psychologists, social workers and occupational therapists. Any member of the multidisciplinary team may function as director of a program within the service. Every patient should be assigned to at least one person on the treatment team and that person should be responsible for coordinating the treatment plan for the patient.

Responsibilities of Staff

General responsibilities of staff are similar to those already outlined for inpatient staff except for the greater degree of community involvement and outreach on the part of outpatient staff. They should also have a good knowledge of community resources and facilities, so they can use these resources appropriately to help the patient through a crisis with as little disruption as possible.

Professional staff should be available to community mental health services for consultation or diagnosis, management and treatment of specific illnesses or conditions about which they have knowledge and expertise, or through their knowledge of a particular patient. In some cases, outpatient personnel may staff a psychiatric clinic in the community. Outpatient staff may make home visits to assess, monitor or intervene as needed in order to prevent a breakdown in social functioning.

Medical Direction

Medial direction and supervision should be the responsibility of a certified psychiatrist, who should administer all medical treatment policies of the psychiatric outpatient service.

When services are provided through community clinics and teams, their function should be closely coordinated with the hospital outpatient services.

Accessibility of Units

Ideally, for the majority of the population, no person should be more than one hour away from general hospital psychiatric services as defined in these guidelines. However, recognizing that this is not always possible, a person should:

- have access to an outpost with appropriate telecommunication support to staff for the management of emergencies;

- be within one hour's travel time from a community-based mental health service that is in contact with general hospital psychiatric services; or

- be within four hours' travel time (including readily available air service) from general hospital psychiatric services.

4.7 Personnel

Staff Allocation

Outpatient services should be provided on a five-day-a-week basis, at the very least. If possible, evening and weekend services should be provided for patients who cannot attend during the day, so that they do not have to choose between resuming work and continuing treatment.

Treatment staff should consist of psychiatrists, nurses, psychologists, social workers and occupational therapists, with the addition in teaching hospitals, of psychiatric residents and other graduates. In general hospitals, other specialists such as neurologists, pharmacists, physiotherapists, recreational therapists or dieticians would be available for consultation.

A receptionist-secretary devoted to outpatient services is essential. Additional clerical and secretarial staff should be provided as required.

The numbers and types of staff required will depend on demand pattern, services offered and resources available in a particular area.

Staff Training and Qualifications

In addition to training and qualifications outlined in section B.6, staff working in outpatient settings should have special skills and experience to enable them to work with patients in the community. These skills would include the ability to visit and work with patients in their own homes and to respond to an emergency situation. Staff should be well versed in crisis management; they should be able to determine when it is appropriate to recommend admission of a patient to hospital and when it is more relevant to intervene in the patient's environment so that the patient can continue to function independently.

Strong assessment skills are necessary to determine precipitating factors in the patient's request for outpatient treatment.

Outpatient staff will require special training in dealing with difficult-to-manage behaviour.[41]

4.8 Space Allocation Utilization and Special Design Features

The outpatient service should have access to therapy areas, examination and treatment rooms and interviewing space, as well as to adequate conference and group therapy rooms. There should be a staff area for record purposes and control of medications. Some of the safety features described in 2.8.2 of the Inpatient section will also apply to the outpatient setting, for example the safe keeping of drugs and medical gases.

5. CONSULTATION AND LIAISON

Definition of Service

Consultation and liaison are distinct activities. Consultation refers to the traditional evaluation of patients at the request of another service; liaison refers to linking with members of other units or wards and facilitating and coordinating plans for patient care.

Patient Population

The main thrust of service is to the emergency care of acute psychiatric illness in medically ill patients. Particular concern is generated by psychotic and suicidal patients.

Other functions include:

- Psychotherapeutic interventions in patients severely depressed by a life-threatening or chronically disabling physical illness.

- Diagnostic assistance with unexplained symptoms.

- Staff support for patients with severe personality disorders and chronic brain syndromes when these patients are seriously disruptive to the routine of the ward and at times threaten the safety of other patients.

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41 See D.2: "The Potentially Aggressive Patient"

Patient Profile Consideration

It is believed that many adult patients with physical illnesses have significant emotional or psychiatric problems warranting evaluation and treatment. In the presence of a life-threatening medical illness, the prevalence of psychiatric illness appears to be even higher. There seems to be a widespread failure to recognize the presence of psychiatric disorders in conjunction with physical illness since only a small percentage of such patients are referred for psychiatric consultation. Such failure to diagnose and treat psychiatric illness/disorder can increase morbidity and mortality in these patients.

Numbers also seem to indicate that the elderly population is particularly susceptible to this problem which is often compounded by misuse or overuse of medication.

D. SPECIAL CONSIDERATIONS

1. CASE MANAGEMENT

The value of case management in facilitating mental health treatment has long been accepted in the community and is now rapidly becoming acknowledged in the hospital. Because mental illness is often characterized by longer term treatment than acute medical care, case management is necessary to ensure that the patient receives appropriate help when necessary. Also, for a variety of reasons, mental health care is often less accessible than physical health care and patients often require help in accessing services.

Case management helps to ensure continuity of care for the patient, by identifying required services in the community, directing the patient to the services and following up on patient status and compliance with treatment. The case manager builds a relationship of mutual trust with the patient and family and thereby provides a constant source of support and encouragement. The role of the case manager is to facilitate interdisciplinary communication and to coordinate inpatient and outpatient care. The case manager therefore needs good collaborative skills and the ability to facilitate interagency cooperation. The case manager should ensure that appropriate liaison takes place and continuity of care is maintained. When patients are referred to specialized clinics such as a schizophrenia clinic, the case manager can also ensure that they keep in touch with the professionals who had previously been treating them.

Whereas the role of case manager has traditionally been assigned to the social worker, any member of the mental health care team can assume this role, providing he or she has the appropriate skills. Necessary skills include:

- ability to relate to the patient and family;
- knowledge of treatment procedures and their effects;
- knowledge of therapeutic drugs and their effects on patients when they are taking them or cease to take them;
- knowledge of the various resources in the community including the social services, e.g. vocational rehabilitation;
- ability to enable and encourage the patient to seek appropriate help and to follow through on treatment recommendations;

- ability to work well with professionals in the hospital and the community; and

- ability to act as an advocate for patients who are unable to act for themselves.

Case management can be cost effective as it discourages duplication of care and facilitates early identification of conditions that could lead to a crisis, requiring more expensive levels of care, such as inpatient admission.

2. THE POTENTIALLY AGGRESSIVE PATIENT

Every hospital department may have a problem with patients presenting unacceptably aggressive behaviour to self or to others. Conditions commonly associated with such potentially harmful behaviours include: deliria, toxic states, neurological, postictal states, psychotic states, post partum illnesses, and substance abuse, especially when associated with personality disorder.

Management should be directed at preventing harmful aggression rather than exclusively attempting to deal with it once it is happening or has already occurred. While flexibility of approach must be maintained, there are, nevertheless, specific strategies which can be applied so that difficult situations can usually be prevented.

Effective prevention and management of violent acts depends on the education and preparation of staff working in critical areas. All staff working in these areas should receive basic training in recognizing signs and circumstances which may be precursors of destructive behaviour. In addition to the clinical states listed above, some predictors are: expression of violent thoughts or threats, increasingly excited or agitated behaviour, abnormal posture, past history of violent acts, and availability of a potential victim.

Management of violence with crisis intervention techniques generally has five basic phases: assessment, planning, intervention, evaluation and follow-up. Unplanned interventions by staff are likely to provoke rather than calm the situation.

In hospitals that have established psychiatric programs, it is recommended that a core group or team, highly trained in the control and management of violence, be established. The team should be available on a 24-hour basis within minutes of being paged. Team members may work in many areas of the hospitals but are on call to

assemble immediately at the location of crisis. In smaller hospitals some provision should be made to ensure control and management of violence.

Since these situations often involve ethical and medical-legal issues, clear policies are required relating to patient management and organization of support structures including legal consultation. Written policies and procedures should be available to all staff.

3. PATIENT'S RIGHTS

Every patient has the right to expect a high quality of health care and to expect that his or her basic human rights will be respected. Mental health professionals should be prepared to provide patients with comprehensive information about any proposed treatment plan, including effects of drugs and other biological treatments. Informed consent for medications and other treatments should be obtained where possible. Staff also have a duty to inform the patient, family and community of the legal and civil rights of patients. When the patient is deemed to be incompetent, informed consent should be obtained from the family or from the appointed trustee.

In addition, every effort must be made to ensure confidentiality of patient records and sensitive information. Particular attention must be given to safeguarding computerized records.

3.1 Patient Advocacy

Some provinces have instituted patient advocacy programs with the mandate of protecting the legal and civil rights of patients in hospitals. Their mandate is to inform the patient, the family, hospital staff and the community about patients' legal and civil rights; to help to resolve complaints made by psychiatric patients through negotiation; to investigate alleged incidents and institutional responses to them and to refer patients, when necessary, to outside community advocacy resources (for example, lawyers or physicians) who may offer a second opinion. Any provincial department considering setting up a patient advocacy program should ensure that it is compatible with their particular provincial mental health act, and should be aware of administrative and legislative provisions in the region or province before embarking on such programs. Hospital staff should be encouraged to consider how they want to respond to the patient advocacy movement, through multidisciplinary discussions or seminars.

3.2 Assessment of Competency

This is a legal matter which, in Canada, lies wholly within provincial jurisdiction. Each province has its own body of mental health legislation which applies to the treatment and management of persons with mental disorders. Provinces are consulting together to bring some degree of uniformity to their individual mental health statutes. Reference should always be made to the specific statutes of the provincial jurisdiction concerned.

3.3 Accommodating the Certified Patient

Staff of a psychiatric facility should be fully informed about the legal context in which the facility exists. Legal requirements vary and are stated in the Mental Health and Human Rights Act or similar legislation of each province. However, provincial statutes are subject to the Canadian Charter of Rights and Freedoms. Relevant sections include, but are not limited to:

Section 7: "Everyone has the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

Section 9: "Everyone has the right not to be arbitrarily detained or imprisoned."

Section 10: "Everyone has the right on arrest or detention a) to be informed promptly of the reasons therefor; b) to retain and instruct counsel without delay and to be informed of their right and c) to have the validity of the detention determined by way of habeus corpus and to be released if the detention is not lawful."

Under the general terms of the Federal Charter and of most provincial legislation, the review process:

- must be accessible on request to the patient, his or her counsel or representative;
- must permit the patient to be present, and to call and question witnesses;
- must place the onus on the physician who completed the committal form to justify the detention;

- must provide for access to any documents or material that may be needed by the independent review tribunal;

- must specifically provide for the patient's right to counsel;

- must provide for an appeal of the tribunal's decision.

The procedural manual of the facility should contain a clearly articulated statement concerning these matters. The clinical record of committed patients should contain a written record of the admission procedure, the information given to patient and family, and the fact of notification of a legal officer where required by provincial legislation.

3.4 Guardianship

Guardianship is a specific civil rights issue which provincial jurisdictions are beginning to address. In the absence of adequate legislation on guardianship, mental health professionals should be vigilant about possible violation of patient property rights. This is a particular problem for the elderly and difficulties often arise with regard to the comprehensiveness, permanence and extent of legal guardianship. An elderly person under full guardianship loses many of his or her civil rights and may permanently assume the legal status of a minor. It is, therefore, wholly improper that incompetence and guardianship proceedings should ever be hasty, ill-considered or routine.[42]

4. COMMUNICATION AND CULTURAL FACTORS

The experience of being in hospital can be traumatic for anyone. It is compounded for patients who do not speak the predominant language or whose cultural values or customs are very different from those of the staff and other patients.

In a multicultural society such as ours, hospital administration should make every effort to provide translators for patients who speak a different language and who do not have friends or family to interpret for them. In some cases the use of an outside interpreter with knowledge of medical/health terminology may be preferable to using family or friends as the interpretation is likely to be more accurate and

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[42] Working Group on Legal Issues, "Legal Isssues in the Care of the Mentally Impaired Elderly Persons",, Canada's Mental Health, Vol. 35, No. 2, June 1987

objective. Where there are large local cultural groups, the hospital should make every effort to provide staff who can speak the particular language and understand the culture of each group.

In assessing the patient's psychological situation, it is essential for hospital staff to understand the patient's belief system, since this may indicate how the patient thinks his or her problem was caused and how it will be cured. It is particularly important to assess the extended family's system or network in order to obtain a proper perspective on the patient's total life.

Hospital staff must be sensitive to the differences in values and customs of patients of other cultures and respect these differences. Where possible, provision should be made for patients to observe traditions that have cultural or religious significance for them. Special dietary and other customs should be accommodated to the extent possible.

Hospitalized patients from different cultures may feel very isolated or lonely during their stay and may appreciate friendly visits from someone who speaks their language and is aware of their culture.

These services should be provided as a component of all psychiatric services of the general hospital.

5. INFECTIOUS DISEASE[43]

All provincial authorities and professional licensing bodies require that hospital and medical staff provide psychiatric care to patients with both psychiatric disorders and infectious diseases. Problems of contagion may be exacerbated when infected patients are behaviourally disturbed and hospitals should have written policies and procedures for treating such patients. These should deal with such matters as accommodation, staff protection, handling of contaminated materials and biological waste.

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43 For further information on infection control (including HIV), refer to Infection Control Guidelines, Isolation and Precaution Techniques, 1985 and Occupational Health in Health Care Facilities, 1986, Bureau of Communicable Disease Epidemiology, and Health Services Directorate, Department of National Health and Welfare

AIDS (HIV Infection)

Patients suffering from AIDS or AIDS-related conditions (ARC) have needs and problems which call for special planning and consideration on the part of hospitals and other health-care givers. In addition to the better known serious and life-destroying disorders of AIDS, there may be neuro-psychiatric conditions arising from organic brain involvement and also moderate to severe states of anxiety and depression. As the incidence of AIDS increases, the number of patients presenting in general hospital psychiatric units with disturbed behaviour associated with AIDS will also increase.

With this group of patients, perhaps more than any other, the need for multidisciplinary team work, for consultation and collaboration between psychiatric and other health-care professionals, and between health-care professionals, social agencies and self-help groups, becomes acute. AIDS patients frequently experience financial devastation resulting from inability to work, social ostracism and disruption of friend and family relationships. They may require emergency and on-going assistance with housing, transportation, food and basic care. In the absence of special residential and counselling facilities for AIDS patients in the community, restricting hospital bed stays may become impossible. There is a strong case for the general hospital in conjunction with other agencies to provide leadership in stimulating the development of community and institutional services. In the treatment of AIDS patients, standards of infection control apply.

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13. "Geriatric Psychiatry in the Emergency Department: Characteristics of Geriatric and Nongeriatric Admissions," H.W. Waxman et al., Journal of the American Geriatrics Society, Vol. 30, No. 7, pp. 427-432, July 1982.

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15. "Day Hospitalization Instead of Inpatient Care for Psychiatric Patients," J.E. Gudeman, M.F. Shore and B. Dickey, New England Journal of Medicine, Vol. 308, no. 13, pp. 749-753, March 1983.

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APPENDICES

LEVELS OF PREVENTION

Recent years have seen an increasing emphasis on prevention in the area of mental health. Caplan[44] distinguished three levels of prevention of mental disorder:

1. **Primary Prevention:** in which interventions are aimed at whole communities rather than individuals (for example there is a direct relationship between economic deterioration and problems such as family violence and emergency room presentations). The goal is to provide sufficient biological, psychological and socio-cultural resources to the community to enable its members to cope successfully during stressful periods throughout their lives. It is distinct from early identification and treatment.

2. **Secondary Prevention:** where efforts are targeted at high-risk groups (e.g. the unemployed, victims of violence, the chronically ill and their families) with the aim of early detection and prompt treatment of psychiatric disorders.

3. **Tertiary Prevention:** where the goal is the maximal rehabilitation and community reintegration of the recovered psychiatric patient following treatment (for example community programs for those with residual impairment to help them access social supports). This requires close collaboration of health services with social services: income support, housing, employment, activity programs and sheltered work settings.

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44 Caplan, G. (1964) Principles of Preventive Psychiatry, New York: Basic Books.

APPENDIX II[45]

THE CATCHMENT AREA

The catchment area is a concept that many consider fundamental to coordinated service planning. A catchment area geographically delimits a population for whom services are to be provided. The area may encompass a city, or it may be an outlying rural area or a particular region of a province. Large metropolitan centres may have to be subdivided into several catchment areas. In each case, like the police or fire departments, the health and social services take responsibility for providing comprehensive services for all people within each clearly defined area. Geographic characteristics, existing service jurisdictions, transportation patterns, population distribution and other factors must be taken into account when determining the size and boundaries of a catchment area. This requires the active involvement of persons familiar with the local area and its service systems.

Since the size and demographic and social composition of the area are known, a more rational development of resources and service planning can take place. A numerical base for planning mental health services can be established by applying what is known of the epidemiology and natural history of mental disorders. Further refinement can be added, with data on existing services and utilization patterns in the area, and more detailed information on the socio-economic composition of the population to be served. The proportion of persons with psychiatric problems relative to the rest of the population is important in that it can determine both the size of the funding base and the degree of probable pressure on facilities for mental health services.

In addition to providing a useful framework for service planning, a catchment area establishes eligibility for care. Accessibility is improved, as patients know where they are supposed to go and have the benefit of being served in their own neighbourhood. The catchment area can promote continuity of care by permitting the development of single-entry service systems and clearly marked pathways through the system.

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45 The text in this appendix is taken from the text Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders, Mental Health Division, Health Services Directorate, Health Services and Promotion Branch, Department of National Health and Welfare, 1987. Certain words have been changed to reflect the general population requiring psychiatric services rather than just the elderly population.

A catchment area also defines the accountability of service providers, who become responsible for all patients in their area. It becomes more difficult for particular populations to be neglected when each geographic area has its assigned services. If the catchment area forms part of a larger organizational unit, such as a district or region, it is not essential for each area to possess the whole range of services. The resources of the larger geographic unit can be linked regionally, so that all catchment areas have access to all key facilities, though not necessarily within their own boundaries. This is the case in Manitoba, where catchment districts for long-term care are operationally linked within seven large regions covering the whole province.

However, there are problems inherent in the catchment area concept. The division into catchment areas presupposes an organization of health and social services which can be conveniently rearranged in this way, but this is not always the case. Existing boundaries determining the scope of various health and social services may correspond to natural divisions based on geographical or historical patterns, but are more often administrative constructs imposed by governments, local health councils, hospital or other boards, or individual programs. In some provinces there are catchment areas for psychiatric services, long-term care and home care but these do not necessarily have the same boundaries. Community mental health teams do not always operate within the same catchment areas as hospital-based psychiatric services, and may lack access to hospital beds nearby. Coordination of services for the mentally ill thus becomes difficult.

The relocation of patients may also pose problems unless the catchment area concept remains flexible. Criteria of eligibility for services may differ between areas, as in different provinces, and patients may have a lengthy wait before receiving services in a new area. Other problems may arise in areas with extremely large populations or with prestigious facilities which attract patients from afar.

Such problems can be reduced significantly through negotiation and cooperative planning. Because people with mental disorders require a range of health and human services and are often referred for failure to cope with the activities of daily living, effective and comprehensive care is best achieved when all relevant services (not just formal psychiatric services) are coordinated within a catchment area.

APPENDIX III

A. EXAMPLES OF PREVENTION AND INTERVENTION PROGRAMS:

1. NAPPI (Non-Abuse Physical and Psychological Intervention), Box 473, Auburn, Maine, USA, 04210

2. Prevention and Management of Disturbed Behaviour Program, Selkirk Mental Hospital, Selkirk, Manitoba

3. Professional Assault Response Training, Alberta Hospitals, Ponoka, Alberta

4. Team Concept - Crisis Intervention, Sir Mortimer B. Davis Jewish General Hospital, 3755 Côte Ste-Catherine Road, Montreal, Quebec, H3T lE2

   Attention: Emergency Psychiatry, Head Nurse/
   Chief Psychiatrist

B. EXAMPLES OF MODELS OF NETWORK OF SERVICES

1. Alcohol and Substance Abuse - Thunder Bay Hospital

2. Annapolis Valley - Mental Health Services

3. Community Resource Consultants of Toronto

4. Greater Vancouver Mental Health Services

5. Transition communautaire.

ADMINISTRATIVE ORGANIZATION, POLICIES AND PROCEDURES

Guidelines for administrative organization, policies and procedures for institutional programs were formulated after a review of provincial, national and international information.

It is hoped that the following outline will serve as a guide for the development of more comprehensive and specific policies in order to ensure the most effective and efficient delivery of patient care in these units.

I. PHILOSOPHY, ROLES AND OBJECTIVES

- Philosophy, roles and objectives of the program
- Type of patients serviced by diagnosis and/or severity of illness
- Services provided
- Restriction of service, if any

II. ORGANIZATION OF PROGRAM

- Governing board responsibility
- Relationship with administrator and medical staff
- Program management

(i) Specific responsibilities of staff

- Medical director
- Other medical staff
- Nursing staff
- Other staff

(ii) Committees

- Membership to be defined by discipline and number

- Terms of reference to be defined
- Provision for consultation with appropriate hospital and medical staff
- Schedules for formal and ad hoc meetings

III. POLICIES FOR OPERATION OF PROGRAM

1. General

- Admission authority (Identification of individual(s) who have authority to admit)
- Admission priorities by:
    - Diagnostic category
    - Clinical condition
- Admission orders
- Medical orders
- Emergency admission standing orders
- Discharge policies and planning
- Length of stay by diagnosis
- Infection control and isolation
- Handling of emergency situations including C.P.R.
- Emergency delegation of responsibility to medical, nursing and /or other staff
- Research/clinical investigation
- Palliative care, determination of death, authorization for autopsies, handling of bodies
- Referral, consultation (mandatory and other transfer, follow-up)

2. **Staff**

- Selection criteria: education, experience, interests
- Criteria for granting medical/clinical privileges
- Medical coverage/Staff coverage of service
- Delineation of student and supervisor roles including responsibility, authority and accountability
- Position descriptions
- Orientation and continuing education
- Performance evaluation
- Volunteers

3. **Patient**

- Patient's rights
- Patient identification
- Family participation
- Confidentiality
- Patient/family education
- Patient valuables, assets and belongings
- Consent for treatment
- Visiting privileges

4. **Safety**

- Safety and accident prevention
- Reporting of accidents and incidents
- Equipment maintenance and safety

- Fire and disaster plan
- Use of restraints

5. **Quality Assurance**

- Practice standards
- Continuing evaluation of effectiveness of service
- Patient status assessment on admission and discharge
- Incident reports
- Patient care review
- Infection control
- Audits: medical and nursing care, concurrent and retrospective
- Peer review
- Morbidity/mortality review
- Employee performance appraisal
- Product and equipment use and evaluation

IV. PROCEDURES

- Elective procedures
- Emergency alert system procedures
- Medical record and statistical procedures
- Policy and procedure manuals

LIST OF GUIDELINES FOR INSTITUTIONAL PROGRAMS

The following guidelines have been prepared by the federal-provincial Subcommittee on Institutional Programs Guidelines. These guidelines were requested by the Federal-Provincial Advisory Committee on Institutional and Medical Care Services. Some of the guidelines are updated versions of guidelines previously published by the Subcommittee.

Addiction Services in Hospitals (1984)
Adult Long Term Institutional Care (1984)
Adult Psychiatric Services Provided by General Hospitals
Assessment and Placement for Adult Long-Term Care: A Single-Entry Model (1988)
Breast Imaging Services: Mammography (1986)
Burn Unit (1985)
Cardiovascular Services in Hospitals (1986)
Child and Adolescent Psychiatric Services Provided by General Hospitals (1980)
Child and Adolescent Services in General Hospitals (1982)
Child and Youth Long Term Services (1985)
Computed Tomography (1986)
Day Surgery Unit (1982)
Dental Care Units in Hospitals (1979 under revision)
Diabetic Day Care Unit (1978 to be revised in 1988)
Diagnostic Imaging Services and Systems: An Overview (1986)
Diagnostic Ultrasound Facilities in Hospitals (1985)
Emergency Services in Hospitals (1981 under revision)
End-Stage Renal Disease Program (1986)
Geriatric Day Hospitals - Geriatric Unit in a Hospital (1979)
Hospital Day Medicine (1984)
Intensive Care Unit (1986)
Magnetic Resonance Imaging (1986)
Nuclear Medicine in Hospitals (1985)
Organ and Tissue Donation Services in Hospitals (1986)
Palliative Care Services in Hospitals (1981, to be revised in 1988)
Patient Hostel Unit (1978)
Perinatal Intensive Care Units in a Perinatal Care Network (1986)
Pre-Hospital Emergency Services (1985)
Pulmonary Function Laboratories (1982)

Reuse of Disposables: An Information Report (1985)
Spinal Cord Injury Program (1986)
Stroke Program (1986)
Vital Organ Transplant Centres (1987)